

EFFECTS OF EARLY CHILDHOOD TEACHER DELIVERED PLAY THERAPY
INTERVENTION ON THE SOCIAL SKILLS OF YOUNG CHILDREN:
A PILOT STUDY

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As I was about to start work on my thesis, the people of Christchurch experienced a series of devastating earthquakes. Suddenly my peaceful family home became a busy place, full of friends and their little children who had lost their homes and were terrified by this unforeseen and frightening event. It was during this most trying and stressful time that I first thought about using play as a means of helping children.

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Abstract

The growing number of young children exhibiting conduct problems is a cause of serious concern for many early childhood teachers. Past research has shown that child centred play therapy (CCPT) may be effective for addressing conduct problems. However, little research has been carried out to study the impact of CCPT on children exhibiting these problems, through training early childhood teachers in using CCPT strategies. Therefore, the goal of this pilot study was to explore whether young children who have persistent conduct problems in early childhood settings in New Zealand would show improved behaviour following their early childhood teachers learning some play-therapy strategies. It also aimed to gather information from teachers about the suitability of play therapy strategies within the context of the New Zealand early childhood system.

Two early childhood teachers and two children, aged 4 years participated in the study. Following the teachers' training, a decrease in problem behaviour and a notable increase in positive play behaviour were observed for the two child-participants. These positive changes corresponded with the improved *Strengths and Difficulties Questionnaire* (SDQ) (Goodman, 1997) scores as measured by the teachers. The *Total Difficulties* scores gained for both children were in the *clinical* range at the beginning of the study and had improved to the *normal* range at the follow-up. The results also showed that the teachers appeared to have benefited from the training and were very satisfied with the intervention outcomes. They found the training acceptable and intended to continue using play therapy strategies in their centre.

The findings of the current study extend previous research by demonstrating the teachers' ability to deliver CCPT strategies. Some limitations of the current study included the limited number of observations during baseline, utilising teachers involved in the CCPT training as the source of data on children, and the absence of the parent report measures. The study findings have some important implications for early childhood centres and for further research.

Chapter 1 Introduction

I work in a private early childhood centre. We have a couple of children who have exhibited highly aggressive and disruptive behaviour; they would constantly kick, hit, bite and scratch others. They refuse to share things and don't know how to play with others in a nice and friendly manner. I have tried different strategies but nothing really works, which has left me feeling frustrated, exhausted and helpless... I'm also getting extremely worried about the future of these kids. I know that if we don't do something about this right now it will spiral out of control, and result in these children being unable to have a happy life in society. Please help! (Liana, 2013, para. 1).

While many early childhood teachers occasionally have to deal with aggression and disruptive behaviours in children, teachers of children with conduct problems may face such behaviours far more frequently. This takes time away from positive delivery of the early childhood curriculum and engaging activities and often puts added stress on the teacher, the child, and other children in the early childhood centre (Webster-Stratton, 2012). Persistent aggressive and disruptive behaviours, which cause much stress for the child, their parents, teachers, and peers are described by Blissett et al. (2009) as defining characteristics of childhood conduct problems.

Childhood Conduct Problems: New Zealand Context

Over the past 10 years, there have been increasing concerns expressed by New Zealand early childhood teachers about a growing number of children exhibiting conduct problems (Ministry of Education, 2012; Tyler-Merrick & Church, 2012). It is estimated that, at any point in time, from five to 10 per cent of New Zealand children will display conduct problems severe enough to require intervention (Blissett et al., 2009). Rates for conduct

problems are even higher for Māori tamariki and it is reported that from 15 to 20 per cent of Māori children have conduct problems (Blissett et al., 2009). There is also some evidence that a significant percentage of young Pacific children display conduct problems in the *clinical* range and require intervention (Blissett et al., 2009).

The Importance of Intervention

These trends are concerning as conduct problems have negative implications for everyone, not just for the young child, their parents and teachers (Blissett et al., 2009; Carr, 2009b; Scott, 2008; Webster-Stratton, 2012). Children showing an early onset of conduct problems characterised by aggressive and oppositional behaviour starting as early as two years of age are at a greater risk for adverse outcomes later in their life, including underachievement, school failure, unemployment, early onset of alcoholism and substance abuse, antisocial behaviour, delinquency and a wide range of mental health issues such as anxiety, depression, and suicidal behaviours (Blissett et al., 2009; Scott, 2008; Webster-Stratton, Reinke, Herman, & Newcomer, 2011). These children are also susceptible to the negative influence of antisocial peers later in their life (Lochman & Wells, 2002) which may lead to early involvement in criminal activities and portends a lifetime criminal path (Blissett et al., 2009; Chamberlain & Reid, 1998; Hutchings et al., 2007a; Miller-Johnson, Coie, Maumary-Gremaud, & Bierman, 2002; Scott, 2008).

If left without intervention, conduct problems may result in severe financial costs for the government. It has been estimated that use of services (e.g., health, social, education) is 10 times higher for this population (Blissett et al., 2009; Edwards, Céilleachair, Bywater, Hughes, & Hutchings, 2007; Webster-Stratton, 2012). These estimates do not take into account the distress associated with the effects of severe conduct problems to the individual and those around them (Blissett et al., 2009). It has been argued “that there is no other

commonly occurring childhood condition that has such far-reaching implications for later development” (Blissett et al., 2009, p. 1). Therefore, conduct problems in young children are a concern for New Zealand society as a whole due to their financial costs and negative long-term implications.

It is believed that certain risk factors may pre-dispose young children to developing conduct problems (Carr, 2009b; Webster-Stratton, 2012). In particular, Harstad and Barbaresi (2010) specify four categories of factors associated with an increased risk of conduct problems.

These categories are biological, individual, family, and social/school. Biological factors may include genetic factors, complications during the antenatal and perinatal period, brain injury and exposure to environmental toxins. Individual factors may be cognitive impairment, difficult temperament, hyperactivity, and learning difficulties. Among family factors are solo parenting, family disorganization, domestic violence, parent-child conflict, and maternal mental health problems. Social/school factors are represented by low socioeconomic status, neighbourhood violence, peer rejection, and being at a disorganized or dysfunctional education setting (Carr, 2009b; Harstad & Barbaresi, 2010). Rather than a single risk factor operating in isolation, the accumulation and interplay of these factors appear to contribute to the development of conduct problems in young children (Carr, 2009b; Guerra & Bradshaw, 2008; Harstad & Barbaresi, 2010; Webster-Stratton, 2012).

Behavioural Parent Training

One of the approaches to addressing conduct problems in young children is behavioural parent training. This treatment approach is considered to be one of the most successful and there is considerable evidence from randomised trials and systematic reviews supporting its effectiveness (Blissett et al., 2009; Fergusson, Stanley, & Horwood, 2009; Hutchings et al., 2007a; Scott, 2008). Parent training programmes are designed to teach parents positive

behaviour management techniques and assist them in improving the quality of their relationships with their child (Scott, 2008). In particular, parents learn how to play with their child, give effective commands, teach children to comply, pay attention to positive behaviour, and respond effectively to problem behaviour by using ignoring, redirecting, time-out and other techniques (Blissett et al., 2009; Webster-Stratton, 2009). Some of the well-developed and well-researched parenting programmes, outlined by Blissett et al. (2009), include: the Incredible Years parenting programme (Webster-Stratton, 1981), Parent-Child Interaction Therapy (Eyberg et al., 2001), the Oregon Social Learning programme (Patterson, 1976) and Triple P (Sanders, 1999).

However, not all families seem to benefit from behavioural parent training programmes (Scott & Dadds, 2009; Webster-Stratton, Reid, & Hammond, 2001). Scott and Dadds (2009) report that from a quarter to a third of families remain unresponsive to this treatment approach, which may be due to the limitations of parenting training (Scott & Dadds, 2009). The first possible limitation is that some families will not participate in parenting training due to their strong personal beliefs, which may be different from the ideas presented in the training. Second, some parents cannot participate due to difficult financial circumstances and/or not being able to get time away from work to attend the sessions, or to afford child care (Scott & Dadds, 2009). A third limitation is that parent training is not effective for about 30% of children, and parents who learn of a family where the training did not work may be unwilling to participate. Another limitation of parent training is that improvements in child behaviour may not transfer to improved behaviour at preschool (Webster-Stratton et al, 2001; Webster-Stratton & Reid, 2003). These limitations of behavioural parent training programmes are described below in more detail.

Strong parental beliefs which may contrast with the concepts presented in behavioural parent training stop some families from participation in the training (Scott & Dadds, 2009). For example, in a study by Barlow and Stewart-Brown (2001) some parents were dissatisfied with the training due to the group leaders having “very specific views about how children should be raised” (p. 127). Scott and Dadds (2009) believe that this happens because behavioural parent training tends to draw from social learning theory which focuses on externally observable behaviour while “ignoring the ‘black box’ of the inner world” (p. 1442). These authors go on to argue that while behavioural parent training equips parents with effective strategies for dealing with their child’s misbehaviour, parental personal beliefs may be much harder to address in parent training. For example, some parents may think that they need not be nice to their child because their child’s difficult behaviour is destroying the parents’ life. Others may believe that they cannot be firm and set limits because their child is too sensitive and limits will hurt their feelings. It is argued by Scott and Dadds (2009) that manuals for parenting programmes do not often guide group leaders on how to approach such issues.

Another category of families who do not often benefit from parenting training is that of economically disadvantaged families raising their children under stressful conditions (McDonald, FitzRoy, Fuchs, Fooker, & Klasen, 2012; Scott & Dadds, 2009). The parent training literature shows that economically disadvantaged families tend to receive minimal benefit from parent training compared to parents who belong to higher socioeconomic groups (McDonald et al., 2012). Retention and attendance rates for low-income families continue to be a challenge for group leaders. Such families often have minimal improvements following training and difficulties retaining learned skills (McDonald et al., 2012; Webster-Stratton, 1998). Yet, these are the families who probably need intervention the most as they often raise children in highly stressful contexts and their children tend to have more severe difficulties

and particularly high risks for developing conduct problems (Scott & Dadds, 2009; Webster-Stratton, 1998). For many low-income parents it may be difficult to devote weekly time for parent training due to work and family constraints, difficulties with child care and transport. For some, parent training may be too remote and inflexible in terms of scheduling and content coverage (Gross et al., 2003; Webster-Stratton, 1998). Also, when only one parent can attend, the differences in the parenting between the parents can lead to family discord. Whatever the reason for withdrawing and non-attendance, even well-resourced parenting programmes often retain only a small percentage of economically disadvantaged families (Scott & Dadds, 2009).

Finally, the improvements in children's behaviour as a result of parenting training do not necessarily transfer to an early childhood education context (Blissett et al., 2009; Webster-Stratton & Reid, 2003). In fact, even when parents successfully complete their training, teachers may still report minimal improvements in children's behaviour at preschool. Some of these children continue to be engaged in aggressive and disruptive behaviour and have difficulties with peers (Webster-Stratton, 2012). It is estimated that up to 30 per cent of children do not show reduction in conduct problems after the first programme (Liberty, 2009) and would still exhibit clinical levels of conduct problems (Webster-Stratton & Reid, 2003). This creates concerns because addressing conduct problems in only one context may not be sufficient to stop the progression of conduct problems into more serious difficulties later in life (Blissett et al., 2009; Scott, 2008).

Early Childhood Teachers Addressing Conduct Problems

An alternative to parent training is the training of early childhood teachers in effective strategies that address the needs of children with conduct problems. Early childhood teachers are significant people in children's lives (Draper, White, O'Shaughnessy, Flynt, & Jones,

2001; Morrison & Bratton, 2010; Thomas, Bierman, & Powers, 2011). In many cases, early childhood teachers spend more time during the week with children than parents caregivers do (Sepulveda, Garza, & Morrison, 2011). A study which followed the progress of around 500 New Zealand children from late pre-school through into secondary school showed that responsive and positive early teacher-child interactions in early childhood result in positive and long-lasting effects on children's behaviour, cognitive and social competencies which is still discernible at age 16 (Hodgen, 2007). The study showed that not only positive relationships with teachers boosted further achievement in children but also became a protection factor for those at-risk by reducing social and behavioural difficulties in later years (Hodgen, 2007).

Findings from two other studies in this area (Hamre & Pianta, 2005; Thomas et al., 2011), reported similar results and showed that a positive emotional climate in the early childhood setting and trusting, secure relationships between young children and their teachers may be significant factors in promoting further academic achievement and reducing behaviour problems in children. Similarly, Howes et al. (2008) reported that children who had sensitive and responsive interactions with their teacher in preschool showed larger gains in academic and social skills in primary school. Thus, early childhood teachers' significance for children, places them in a good position for implementing interventions to influence children's behavioural adjustment (Draper et al., 2001; Morrison & Bratton, 2010; Webster-Stratton, 2012).

New Zealand Early Childhood Resources for Addressing Conduct Problems

Currently, New Zealand early childhood teachers have three major resources for addressing conduct problems at early childhood centres. These resources include: the *Providing positive guidance: Guidelines for early childhood education services* document by the Ministry of

Education (1998); the Early Intervention Service provided by the Ministry of Education that can give teachers access to psychologists (Ministry of Education, n. d.); and the Incredible Years teacher training programme (Webster-Stratton, Reid, & Stoolmiller 2008).

The first resource is *Providing Positive Guidance*, which is a document published by the Ministry of Education (1998) to prescribe legal requirements, along with strategies for effective and positive behaviour guidance in early childhood education settings. This document is one of the core components of early childhood teacher preparation, and is one of the foundation documents in terms of policy and expectations for practice. The Guidelines consist of six parts and focus on the management of behaviour problems in an early childhood environment. Part 1 outlines the purposes of the document and provides a background to the guidelines. Part 2 provides definitions of key terms and examines legal requirements in relation to behaviour management. It further discusses the link between the early childhood curriculum (Ministry of Education 1996), the *Education (Early Childhood Centres) Regulations* (New Zealand Government, 1998), and teachers' interactions with children. Part 3 highlights the importance of a positive climate in an early childhood setting and provides some examples and strategies of how this could be achieved. The Guidelines then provide a variety of strategies for addressing behaviour problems in Part 4, with some examples of effective and ineffective practices. Part 5 addresses a series of common concerns expressed by early childhood educators relating to child behaviour, such as aggression, biting, superhero play, and non-compliance.

The Guidelines have been directing early childhood teachers for more than 10 years. However, the number of preschool and school-age children displaying conduct problems continues to grow. New Zealand Internet forums and newspapers constantly report that early childhood teachers experience great challenges in dealing with a growing number of children

exhibiting conduct problems (Liana, 2013; Brown & Hamilton, 2007). According to Warwick Pudney, a senior lecturer in psychotherapy at the Auckland University of Technology, early childhood teachers today are presented with more aggression and violence from children as they “are enduring kicks, punches, damage to property, hitting of other children and being told to **** off” (Cumming, 2004, para. 3). In addition, since 2008, as a part of the Ministry of Health B4 School Check, more than 100,000 four year olds have been screened for conduct problems, peer difficulties and social and emotional difficulties with the *Strengths and Difficulties Questionnaire* (SDQ) (Goodman, 1997). It has been reported that 10 per cent of these children had high scores in the categories of *borderline* or *abnormal* (Neale, 2012). Thus, if the strategies in *Providing Positive Guidance* (Ministry of Education, 1998) were generally effective in early childhood settings, New Zealand would not have such high rates of conduct problems in preschool and new entrant children.

The second resource available for early childhood teachers is the Early Intervention Service provided by the Ministry of Education. This service provides access to psychologists and Early Intervention teachers who may assess a child and suggest what support they need, with parent consent. Children can be referred to the service from birth to school age (Ministry of Education, 2013b). Early intervention staff observe a child’s interactions in the home setting and in the early childhood setting, and develop strategies to be implemented by parents and early childhood teachers to reduce problems. The staff scaffold and support parents and teachers to provide these services. The child may receive Early Intervention Services from the Ministry of Education, Special Education or other accredited providers (Ministry of Education, 2013b; Ministry of Education, n. d.).

There appears to be two major problems with this resource. First, early childhood teachers may wait for a long period of time before they receive the required assessment and expert

consultation (Durie, 2005; Liberty, in press). Second, this service is only available to the children with severe conduct problems which “significantly affect their ability to participate and learn at home or in an early childhood education setting” (Ministry of Education, 2013b, para. 1). For this reason, teachers of children with moderate conduct problems may not be eligible to receive support they might need. In addition, child and adolescent mental health services in New Zealand are unlikely to provide consultation to early childhood teachers, as they experience heavy referral loads and are more focused on the most severe problems (Durie, 2005).

The third major resource available for early childhood teachers for addressing conduct problems is the Incredible Years teacher training programme (Webster Stratton, 1994). This training programme has recently become available for New Zealand teachers as a part of the *Positive Behaviour for Learning* (Ministry of Education, 2012) initiative, which aims to deliver the programme to 8,260 early childhood and primary teachers by 2014 (Ministry of Education, 2013a). The programme is designed for teachers of children from 3 to 8 years of age; it applies similar behaviour management techniques as in parent training and provides practical strategies for creating a positive learning climate and equips teachers with positive behaviour management strategies (Fergusson, 2009; Ministry of Education, 2013c). Early childhood teachers are required to meet with their colleagues from other centres once a month over the period of six months. The training also includes a follow-up and one full-day session three months later (Ministry of Education, 2013c).

However, there appears to be several barriers associated with availability of this resource to early childhood teachers. First, Tyler-Merrick and Church (2011) believe that due to a limited number of trained group leaders, it will take a long time to achieve coverage New Zealand-wide. Meanwhile, teachers have to wait for training being available in their area. This aspect

may be problematical, especially for those teachers who need immediate support and guidance. Second, the relatively long duration of the training may reduce teachers' willingness and enthusiasm to participate in it. Although the Ministry of Education pays a service to have relieving (substitute) teachers, centre owners may be either unable or unwilling to employ relief teachers on a regular basis for such a long time. Third, there has been a limited amount of research into the efficacy and acceptability of the Incredible Years teacher training programme (Webster Stratton, 1994) in a New Zealand context.

Overall, the resources for management of conduct problems available for early childhood teachers appear to have a number of limitations. In the light of these limitations, early childhood teachers may consider the feasibility and potential benefits of training in play therapy.

Play Therapy Training as Possible Intervention

Play therapy offers several advantages that are likely to make this approach particularly useful for addressing childhood conduct problems. The first advantage is the importance of play to early development. Milteer and Ginsburg (2012, p. 205) argue that play is vital for the cognitive, social, emotional, and physical wellbeing of young children; it is also "a natural tool for children to develop resiliency as they learn to cooperate, overcome challenges, and negotiate with others". Research also shows that play is essential to children's learning as it stimulates the development of language, and mathematical concepts, as well as promoting social and emotional competencies and enhancing physical skills (Alexander, Frohlich, & Fusco 2012; Almon & Miller, 2011; Milteer & Ginsburg, 2012; Nicolopoulou, 2010, Webster-Stratton, 2012). It is not a coincidence therefore, that Māori have traditionally considered play as an important mechanism for learning essential survival skills. For this reason, and with the growth of Te Kohanga Reo, there has been increased understanding of

play as a means of supporting and revitalising Māori culture and language (White et al., 2010).

Another advantage of play therapy is that play is regarded as a natural activity in children's lives (Milteer & Ginsburg, 2012; Landreth, 2011). This view of play has been well supported by researchers from different disciplinary perspectives, such as medical, educational and mental health. Some authors refer to play as child's language (Landreth, 2011) and even consider it "as natural to children as breathing" (Schaefer, 2011, p. 15). The uniqueness of play is that it provides a means of universal expression among children and goes beyond differences in culture, language and ethnicity (Schaefer, 2011). This aspect of play may be especially important within the multicultural context of New Zealand where a large proportion of its citizens belong to more than one ethnic group (White et al., 2010).

Furthermore, play contributes to the development of social and emotional skills which are considered important prerequisites for school readiness and academic success (Milteer & Ginsburg, 2012; Webster-Stratton, 2012). Tannock (2010) believes that even when children are engaged in simple games like chasing each other, important emotional learning takes place: children learn how their peers might respond to changes in the game; they learn how to be creative and problem-solve if their peers decide to adjust the rules or accidentally hurt themselves; and they learn how to negotiate and express what they think to others. Thus, even simple play activities may offer multiple opportunities for exploration of diverse social behaviours, including cooperation, competition, conflict and aggression (Tannock, 2010). In addition, research shows that play promotes children's emotional expression and emotional regulation. In pretend play, for example, children can explore and express negative emotions without any consequences (Holmes, 2010). As children express their negative feelings

through play, they become more able to move on from these feelings into more positive and self-enhancing emotions (Landreth, 2011).

Types of Play Therapy

Play is being utilised in many different types of play therapy. Major types include: family or filial play therapy, cognitive-behavioural play therapy, ecosystemic play therapy and child-centred or non-directive play therapy (Porter, Hernandez-Reif, & Jessee, 2009; Ryan & Bratton, 2008). Filial therapy is a treatment approach originally developed in the 1960s by Bernard and Louise Guerney to address a variety of behavioural and emotional problems in children and parent-child relationship difficulties (Topham, Wampler, Titus, & Rolling, 2011). In filial therapy, parents are placed in the therapeutic role in which they use play therapy skills to bring about positive changes in their children's behaviour (Garza & Watts, 2010).

Cognitive-behavioural play therapy represents a developmentally appropriate adaptation of cognitive-behavioural therapy. In this approach, play is used strategically to deliver cognitive-behavioural therapy techniques to young children (Knell & Dasari, 2011). This approach incorporates a blend of behavioural and cognitive interventions. Behavioural interventions help parents and children to generalise particular skills gained in play therapy to the natural environment. Cognitive methods, on the other hand, result in changes in thinking where children learn to identify negative thoughts and replace these with positive (Knell, 2009).

Ecosystemic play therapy is a dynamic, integrated therapeutic model that focuses on the whole child within their family (Limberg & Ammen, 2008; O'Connor & Ammen, 2013). This approach is similar to other play therapy approaches, in its emphasis on warm and accepting interactions between the therapist and child, and the importance of play as a

primary therapeutic modality. The therapist is responsible for structuring and planning each session and makes decisions on who should participate in the therapy, depending on the child's needs and stage of development, focus of treatment, and ecosystemic variables (Limberg & Ammen, 2008).

Child centred play therapy (CCPT), originated by Virginia Axline (1947), is an approach to play therapy based on the belief that children are capable of finding solutions to their problems by the means of play (Ryan & Bratton, 2008). The distinctive feature of this approach is its non-directive nature. In this approach, the therapist carefully follows the child's lead and ideas, while the child makes choices about what toys to play with, and the direction of play. The role of the therapist is to facilitate a warm and accepting relationship with the child. The therapist actively follows the child's lead by describing the child's actions, restating what the child says, and labelling the child's emotions (Landreth, 2011; Wilson & Ryan, 2005). Unlike the other play therapy approaches, CCPT avoids the use of praise and analysis of children's behaviour and emotional reactions (Wilson & Ryan, 2005).

The Advantages of CCPT for Children with Conduct Problems

Several authors suggest that CCPT is the most promising approach for children with conduct problems (Morrison & Bratton, 2010; Ray, Blanko, Sullivan, and Holliman, 2009). There are two reasons why this approach may be effective. First, children with conduct problems often refuse to follow directions. Research shows that children with conduct problems refuse to comply with teachers' requests about two-thirds of the time, which often leads to power struggles (Webster-Stratton, 2012). Such high rate of noncompliance makes the use of directive play therapy approaches with these children problematic. In contrast, CCPT offers a non-directive approach, which appears to be more suitable for children with conduct problems. In particular, in CCPT therapists avoid giving unnecessary directions which in

turn, may help to avoid oppositional responses and power struggles. Instead, limits are established in a way which provides the child with an acceptable alternative or choice. Choice giving is believed to help the child to learn how to be responsible for making their own decisions; thus, the child is allowed to demonstrate control but in appropriate and positive ways (Landreth, 2011; Ray, 2011b). Unfortunately, children with conduct problems and academic difficulties may have limited opportunities for child centred play, as some teachers tend to underestimate the importance and benefits of child centred play for such children (Landreth, Ray, & Bratton, 2009).

Second, CCPT appears to develop children's emotional self-regulation and the emotional language to appropriately express feelings (Landreth, 2011). Research shows that children with conduct problems have poor emotion regulation and lack emotional understanding. They often have difficulties 'reading' interactive cues and emotions of other children, and tend to interpret peers' actions in a hostile manner. This often escalates aggression and results in peer rejection (Holmbeck, Jandasek, Sparks, Zukerman, & Zurenda, 2008; Lochman & Wells, 2002; Webster-Stratton & Herman, 2010). During CCPT, therapists actively reflect and label children's emotions and feelings, which is found to help children learn vocabulary for expressing emotions. Once children acquire the words for emotions, they are able to learn to describe their emotions to those around them, and self-regulate more easily (Webster-Stratton & Reid, 2009). This, in turn, may positively impact on the quality of children's relationships with their peers and could give them more confidence and skill in social interactions (Landreth, 2011).

Considering the potential benefit of CCPT for children with conduct problems, the next chapter examines the research evidence-base for CCPT.

Chapter 2 Literature Review

CCPT Delivered by Play Therapists

To date, there has been no systematic review of the literature on CCPT. However, CCPT interventions have been included in one meta-analytic literature review devoted to the outcomes of play therapy.

Bratton, Ray, Rhine and Jones (2005) reported a meta-analysis on play therapy interventions. The authors identified 93 play therapy studies published between 1953 and 2000 by using the Association for Play Therapy definition of play therapy. Bratton et al. (2005) coded all studies into two broad groups that included a humanistic (nondirective) play therapy group and a non-humanistic (directive) play therapy group involving behavioural, cognitive and directive play therapy approaches. It was suggested that humanistic play therapy interventions demonstrated large effect sizes while the non-humanistic treatments showed moderate effects. The authors concluded that play therapy duration was a significant factor in the effectiveness of the therapy and it was found that having 30 to 40 sessions of play therapy was the optimal number for achieving positive changes. The age and gender of the child were not found to be significant in predicting the effectiveness of play therapy as children of any gender and age may benefit from it (Bratton et al., 2005).

Since 2005, there have been 14 further studies of play therapy and these studies are described in the following paragraphs. In order to compare the effects across these studies, Cohen's d was calculated by the researcher for main behaviour measures, using pre-test to post-test comparisons where possible. Effect sizes were interpreted according to Cohen's (1988) guidelines: $d = 0.01-0.24$ = small effect; $d = 0.25-0.49$ = moderate effect, and $d = 0.50$ and greater = large effect.

Bratton et al. (2013) conducted a pilot study examining the effectiveness of CCPT on preschoolers identified with disruptive behaviours in the *clinical* range. Children (N=27) in the experimental group received from 17 to 21 individual CCPT 30-minute sessions twice weekly. Children in the active control group (N=27) received from 16 to 20 sessions of reading mentoring twice per week. The CCPT sessions were delivered by counsellors with training in CCPT and the C-TRF (Achenbach & Rescorla, 2000) was used as a measure. At baseline, the mean score for externalising problems was 63.00 and 63.55 for aggressive behaviour indicating a *borderline* range. After the intervention, scores for externalising problems improved to the normal range reducing by an average of 5 points. The calculated pre- and post-treatment effect sizes were large and were $d = 0.7$ for externalising problems and $d = 0.7$ for aggressive behaviour; and $d = 0.81$ and $d = 0.55$ as opposed to the active control group (Table 1).

Garza & Bratton (2005) studied the effects of CCPT on 29 Hispanic children, aged from 5 to 11, exhibiting behaviour problems. The authors used a pre-test post-test comparison group design to evaluate CCPT intervention and curriculum-based small group counselling in treating behaviour problems. The study used the *Behavior Assessment System for Children-Parent Rating Scale* (BASC-PRS) and *Teacher Rating Scale* (BASC-TRS) (Reynolds & Kamphaus, 1992). The children were placed in two groups. One received the CCPT intervention while the other group received a curriculum-based counselling intervention. The sessions were delivered at school, once per week for 15 weeks and were 30-minute in duration. Garza & Bratton (2005) found that CCPT resulted in statistically significant changes in behaviour problems, compared to children who participated in the curriculum-based counselling intervention. Effect sizes calculated for parent and teacher measures were $d = 0.26$ and $d = 0.24$ which indicated a moderate effect (Table 1).

Muro, Ray, Schottelkorb, Smith, and Blanco (2006) conducted a quantitative exploratory study to investigate the effectiveness of mid-term (16 sessions) and long-term (32 sessions) CCPT in relation to child behaviour and teacher stress. The participants were 23 four to eleven year old children who were exhibiting behavioural and emotional difficulties at school. The children received individual 30-minute CCPT sessions. Two types of instruments were applied: *Index of Teaching Stress* (ITS) (Abidin, Greene, & Konold, 2004) for assessment of teacher child relationship stress and *Teacher Report Form* (TRF) (Achenbach & Rescorla, 2000; 2001) to measure changes in child behaviours. Measurements occurred at the baseline phase, mid-intervention (16 sessions), and at the follow-up (32 sessions). Muro et al. (2006) reported that children who received 32 CCPT sessions showed more positive changes in externalising behaviour scores and relationships with their teachers. The effect sizes calculated for the 16-session treatment were $d=0.01$ (small) for *Externalising Problems* and $d=0.28$ (moderate) for the *Teacher Stress* (Table 1). For the 32-session the effect sizes were $d=0.28$ (moderate) for the *Externalising Problems subscale* and $d=0.59$ (large) for *Teacher Stress* (Table 1).

Ray et al. (2009) conducted a quantitative study exploring the effects of CCPT on children's aggressive behaviours reported by teachers and parents. In this study, 41 children aged from 4 to 11 years were randomly placed in either the CCPT group or the waitlist control group. Children in the CCPT group received 14 sessions of 30-minute individual play therapy twice a week. Children in the waitlist control group received no intervention for the duration of the study. Problem behaviour in children was assessed by parents and teachers using the *Child Behavior Checklist* (CBCL) and TRF (Achenbach & Rescorla, 2001) which were completed pre-treatment and post-treatment. Children who received CCPT intervention showed a significant decrease in aggressive behaviours as reported by teachers. This was not matched by parental report data which showed no major changes in children's behaviour between the

experimental and control groups. A calculated effect size for CBCL (Achenbach & Rescorla, 2001) on the *Aggressive Problems* subscale for change over time was $d=0.28$, indicating a moderate effect (Table 1). The effect size for TRF (Achenbach & Rescorla, 2001) on the *Aggressive Problems* subscale was also moderate $d=0.33$ (Table 1).

Ray, Schottelkorb, and Tsai (2007) evaluated the impacts of CCPT on children aged 5 to 7 years with reported symptoms of ADHD and on teacher-child relationship stress. In this pre-test post-test treatment comparison study, 60 children were randomly assigned to either CCPT or reading mentoring (RM) group. The CCPT group received 16 sessions of 30-minute individual play therapy and the RM group received 16 30-minute individual reading sessions. Pre-and post-treatment testings were conducted using the ITS (Abidin, Greene, & Konold, 2004) and the *Conners' Teacher Rating Scale-Revised* (TRF-R) (Conners, 2001). Both groups had statistically significant improvements on assessment ratings related to ADHD, anxiety/withdrawal, and learning difficulties. However, children who received CCPT showed more statistically significant improvements in measurement areas. The CCPT group also showed a greater decrease in aggression and conduct problems with an effect size of $d=0.30$ (moderate) as opposed to $d=0.01$ (small) for the RM group (Table 1).

Table 1

Studies of Child Centred Play Therapy (CCPT) Delivered by Play Therapists

Author and year	Participants' age and number (N)	Measures	Intervention name, place and duration	Who delivered	Significant people involved	Effects
1.Garza & Bratton (2005)	5-11 years N=15 (CCPT treatment) N=14 (group counselling)	BASC-PRS; BASC-TRS (Reynolds & Kamphaus,1992)	CCPT delivered at school once per week for 15 weeks 30-minute sessions	Counsellors with postmasters training and experience in play therapy	No	CCPT vs. Control BASC-PRS Externalising ES, $d=0.26$ BASC-TRS Externalising ES, $d=0.24$
2. Bratton et al. (2013)	3-4years N=27 (CCPT experimental) N=27 (active control)	C-TRF (Achenbach & Rescorla, 2000)	CCPT delivered at preschool twice per week for ≈ 10 weeks 30-minute sessions	Counsellors with training in CCPT	No	CCPT vs. Control C-TRF Externalising ES, $d=0.81$ Aggressive ES, $d=0.55$
3.Muro, Ray, Schottelkorb, Smith, & Blanco (2006)	4-11 years N=23	TRF (Achenbach & Rescorla, 2000; 2001) ITS (Abidin, Greene, & Konold, 2004)	CCPT delivered at preschool and school once per week 30-minute sessions 16 sessions +16 sessions	Counsellors, doctoral level counselling students, one master's student.	No	0 vs.16 sessions TRF Externalising ES, $d=0.01$ ITS (Total stress) ES, $d=0.37$ 0 vs.32 sessions TRF Externalising ES, $d=0.28$ ITS (Total stress) ES, $d=0.59$

Author and year	Participants' age and number (N)	Measures	Intervention name, place and duration	Who delivered	Significant people involved	Effects
4.Ray, Blanko, Sullivan, & Holliman (2009)	4-11 years N=41 N=19 (CCPT) N=22 (wait-list control)	CBCL (Achenbach & Rescorla, 2001) TRF (Achenbach & Rescorla, 2001)	CCPT delivered at preschool and school twice per week for 7 weeks 30-minute sessions; Wait-list control group received no intervention	CCPT: doctoral level counselling students, master's-level students	No	CCPT pre- vs. post-CBCL (aggressive problems subscale) ES, $d=0.28$ TRF (aggressive problems subscale) ES, $d=0.33$
5.Ray, Schottelkorb, & Tsai (2007)	5-11 years N=31 (CCPT) N=29 (reading mentoring)	CTRS-R:S (Conners, 2001) ITS (Abidin, Greene, & Konold, 2004)	CCPT delivered at school once per week for 16 weeks 30-minute sessions; Reading Mentoring (PM) delivered at school once per week for 16 weeks 30-minute sessions	CCPT: doctoral level counselling students, master's-level students RM: undergraduate students	No	CCPT pre- vs. post-CTRS-R:S ES, $d=0.30$ ITS (aggressive/conduct disorder) ES, $d=0.30$ PM pre- vs. post-CTRS-R:S ES, $d=0.60$ ITS (aggressive/conduct disorder) ES, $d=0.01$

There have been a number of case studies devoted to the evaluation of the effects of play therapy (Table 2). In 2010, Campbell and Knoetze conducted a qualitative, interpretative case study assessing the effects of repetitive symbolic play in CCPT on a 6-year-old boy's adjustment in home and in school environments. The participant of the study was Andrew, described as a boy with delayed social and emotional skills who was also unhappy and irritable. Andrew received 30 CCPT sessions once a week over a year. Intake interviews with Andrew, his father and teacher; video-recordings of play sessions; process notes by the play therapist's supervisor; session records and records of feedback sessions with Andrew's father, teacher and speech-therapist were used to obtain qualitative data. The results showed that Andrew's repetitive symbolic play in the context of an empathetic relationship between Andrew and his therapist generated Andrew's self-directed healing and a positive change in his behaviour. Andrew's teacher reported that he became more competent and confident, which was shown through his diligent schoolwork, participation in extracurricular activities and new friendships. At home, Andrew showed increased self-confidence (Table 2). The authors reported that at the end of play therapy, Andrew communicated to his play therapist that his world had changed into a safe and secure place with supportive people (Campbell, & Knoetze, 2010).

In a similar case study (Cochran, Cochran, Fuss, & Nordling, 2010a), researchers explored the use of CCPT with a boy aged 7 who was described as being extremely disruptive at school. CBCL (Achenbach & Rescorla, 2001) and TRF (Achenbach & Rescorla, 2001) were used to measure behavioural changes. Qualitative data included the play therapist's observations during the play therapy treatment. In addition, feedback from his teachers, social worker, school counsellor and school principal was collected. The boy received 45-minute individual CCPT sessions twice a week over 14 weeks. The results of this study showed improvements in the total TRF (Achenbach & Rescorla, 2001) scores, which improved from *clinical* to *borderline* (Table 2). The play therapist noted changes in the boy's play "which shifted from tortured, unhappy, demanding, and unsatisfied

to open, joyful, easygoing play” (Cochran et al., 2010a, p. 240). Another important change noted by the therapist was the boy’s improved social progress. Before the treatment, children at school would rarely greet him, but, by the end of the CCPT treatment, at least a few children at school exchanged greetings with him. The boy’s teacher and principal also noted that he made significant academic progress in the following school year and continued to maintain a positive relationship with his peers.

Cochran, Cochran, Nordling, McAdam and Miller (2010b,c) examined the effects of CCPT on two children referred for highly disruptive behaviour, attention and aggression problems. Anton and Berto, both aged 6, were receiving individual CCPT sessions. The CCPT was delivered in 30-minute sessions twice a week at school. Problem behaviours in children were assessed by using TRF (Achenbach & Rescorla, 2001) and therapists’ journals entries on the children’s behaviour. The results for Anton and Berto showed that total TRF (Achenbach & Rescorla, 2001) scores did not improve from *clinical* to *normal* levels (Table 2). Berto’s therapist, however, reported that the intensity and frequency of his acting out behaviours reduced and he was no longer seeking constant attention from his teacher.

Unlike the two studies by Cochran and colleagues, the results of Paone and Douma’s (2009) play therapy case study appeared to be more beneficial. In their study, Bobby, aged 7 with a diagnosis of intermittent explosive disorder, received 16 sessions of play therapy. Before the intervention, his parents reported that Bobby’s behaviour at home was very difficult: he did not follow any rules, was disruptive and often physically aggressive, kicking holes in walls, breaking many of his own toys or impulsively flipping furniture. He displayed frequent temper tantrums and his parents had to intervene to control these difficult behaviours. The authors used parent and teacher feedback and the therapist’s case notes to record Bobby’s progress throughout the therapy. By the end of therapy, symptoms greatly improved, as reported by the parents, who were involved in the therapy by

regularly discussing Bobby's progress with the therapist and by using some play therapy strategies at home. After the conclusion of therapy, his parents reported that Bobby's behaviour shifted to "wonderful" both at home and at school (Table 2). Bobby started to listen to his parents and teachers, he learned to problem-solve in difficult situations and was no longer damaging toys and property. The parents also indicated that problem behaviours, such as running away in public places and tantrums, were greatly reduced. This progress was also matched by improvements at school.

Snow, Hudspeth, Gore and Seale (2007) reported similar results. The authors evaluated the effectiveness of CCPT for children with behaviour problems. In two mixed method case studies children with severe behaviour problems and aggression received six play therapy sessions over 6 weeks. The authors used quantitative and qualitative measures such as CBCL (Achenbach & Rescorla, 2001) and play themes recorded by the play therapist to assess changes in children's behaviour. The results for Andrey, aged 3, and Paul, aged 6, showed that CCPT was equally effective in decreasing the boys' aggression and externalising problems. At baseline, Andrey had *clinical* levels of *Externalizing Problems* and *borderline* levels of *Aggression* on CBCL (Achenbach & Rescorla, 2001). At follow-up, these scores improved to *normal* levels (Table 2). Similarly, Paul's *clinical* levels of *Externalizing Problems* and *Aggression* improved to *borderline* levels (Table 2). The caregivers of both children were involved in CCPT and reported major improvements in behaviour at home.

The above studies show that CCPT delivered by play therapists may be effective in addressing conduct problems in children. Some authors, however, suggest that having teachers, rather than therapists, deliver play therapy can be even more effective (e.g., Morrison Bennett & Bratton, 2011; Smith & Landreth, 2004).

Table 2

Case Studies of Child Centred Play Therapy (CCPT) Delivered by Play Therapists

Author and year	Participant(s)' age and number (N)	Data source(s)	Intervention name, place and duration	Who delivered	Significant people involved	Effects/Effect Category
1. Campbell & Knoetze (2010)	6 years N=1	Intake interviews with Andrew, his father and teacher; video-recordings; process notes by a supervisor; session records; records of feedback sessions with Andrew's father, teacher & speech-therapist.	CCPT delivered at clinic once per week for 1 year ?-minute sessions	Play therapist	Yes	Good
2. Cochran, Cochran, Fuss, & Nordling (2010a)	7 years N=1	TRF (Achenbach & Rescorla, 2001)	CCPT delivered at school twice per week for 9 weeks 45-minute sessions	Play therapist	No	Good TRF Total score improved from 88 (clinical) to 63 (borderline)

Author and year	Participant(s)' age and number (N)	Data source(s)	Intervention name, place and duration	Who delivered	Significant people involved	Effects/Effect Category
3. Cochran, Cochran, Nordling, McAdam, & Miller (2010b, c)	6 years N=2	TRF (Achenbach & Rescorla, 2001); play therapists' journal entries on clients behaviour	CCPT delivered at school twice per week for 9 weeks 45-minute sessions	Play therapist	No	Poor TRF Total score did not improve from clinical to normal
4. Paone and Douma's (2009)	7 years N=1	Parental, teacher's feedback; therapist's case notes	CCPT delivered at clinic 16 sessions for ? weeks ?-minute sessions	Play therapist	Yes	Good
5. Snow, Hudspeth, Gore, & Seale (2007)	3, 6 years N=2	CBCL (Achenbach & Rescorla, 2001); play themes recorded by play therapists	CCPT delivered at clinic 6 sessions for 6 weeks ?-minute sessions	Play therapist	Yes	Good Child 1: CBCL Externalizing Problems and Aggression Scores improved from clinical and borderline to normal Child 2: CBCL scores improved from clinical to borderline

CCPT Delivered by Teachers

Helker and Ray (2009) studied the effects of training early childhood teachers in CCPT on preschool children's behaviour. Children, aged 3 to 4 years, who scored in the *borderline/clinical* range on C-TRF (Achenbach & Rescorla, 2000) participated in the study (N=32). The authors assigned 12 early childhood teachers/teacher aides to the experimental group which received three-stage CCPT training. The first stage was an intensive two and a half day training which covered the concepts and principles of CCPT. The teachers were trained in reflective listening, responding to children's feelings, limit setting as well as ways to structure weekly play sessions with their target children. During the second phase of the training, the teachers were practising new skills with the children in their preschool under the supervision of an experienced therapist. Over 10 weeks, the teachers delivered individual 30-minute sessions three times a week to 19 children. Phase III of the study was a 10-week follow-up period after the end of the training. During this time, the teachers received no training or supervision. Teachers and aides in the control group (N=12) participated in a Conscious Discipline classroom management program and social emotional curriculum and implemented this in their classrooms (Bailey, 1994; 2001).

Unfortunately, the effect sizes could not be calculated as Helker and Ray (2009) did not provide children's C-TRF scores (Achenbach & Rescorla, 2000). However, the authors reported that preschoolers in the experimental group showed a decrease in *Externalising Problems* as compared with the control group children (Table 3). This study also provided some valuable information on teachers' perceptions of the CCPT. Some teachers reported that as a result of the training, they gained a better ability to understand children and to see things from the children's perspective. Some teachers stated that they became more confident in their ability to manage their classrooms. Teachers also reported a number of positive changes in children's behaviour, including an improved

ability to self-regulate and deal with anger, along with gains in self-confidence and academic progress.

Morrison and Bratton (2010) also examined the effectiveness of CCPT teacher training. The child participants were 52 low-income children aged from 1 to 5 years exhibiting behaviour problems at home and preschool. Preschool teachers and teacher aides were placed in either an experimental (N= 12) or a control group (N= 12). The teachers and aides in the experimental group were trained in CCPT. The training consisted of two and a half days of intensive theoretical and experimental instruction, 7 weeks of group training (1 hour per week), followed by 10 weeks of coaching in the preschool setting. During these 10 weeks, the teachers delivered CCPT individually to 12 children three times per week for 30 minutes. The teachers and aides in the control group received Conscious Discipline (Bailey, 2000) instruction aimed at improving teacher-child interactions, promoting children's socio-emotional development and character building. To assess the effectiveness of each intervention, the study used the teacher version of CBCL (Achenbach & Rescorla, 2000). The effect size calculated for *Externalizing Problems* pre- and post- CCPT intervention for the experimental group was $d=0.87$, indicating a large treatment effect, while the between the group comparison effect size was $d=0.16$ which is considered small (Table 3).

A more recent study by the same authors (Morrison Bennett & Bratton, 2011) evaluated the effects of teacher training in CCPT on children identified with clinical levels of behavioural problems. In this pilot study, teachers and teacher aides were placed in two groups: experimental (N=12) and active control (N=12). The first group received CCPT training and supervision and the second group of teachers participated in the Conscious Discipline training (Bailey, 2000). Following the CCPT training, the teachers trialled CCPT concepts individually with 11 children, aged from 3 to 4 years for 10 weeks three times per week for 30 minutes. In the CCPT group, the children's level of externalising problems improved, as measured with CBCL (Achenbach & Rescorla, 2000) between

pre-test and post-test conditions. This was supported by a large effect size of $d=0.83$. In addition, the CCPT group showed greater improvements in externalising behaviour with an effect size of $d=0.92$, compared with a small effect size of $d=0.18$ for the active control group (Table 3).

In an earlier study by Post, McAllister, Sheely, Hess and Flowers (2004), the effects of CCPT teacher training were also examined. For this study, nine early childhood teachers from two preschools received 10 weeks of CCPT training, which involved role play, modelling and home assignments. Following this, the teachers participated in 13 practice-based, two-hour group sessions focussing on assisting teachers with generalisations of play therapy skills at their work place. During the first stage of training, each participating teacher was delivering seven individual play sessions over 7 weeks to one child with specific behaviour problems such as aggression, social withdrawal, or social, academic or transition difficulties. All children ($N=18$) in this study resided in low socio-economic areas characterised by poverty, substance abuse, crime and single and teenage parenting. A comparison group consisted of eight teachers from the same preschools. The study used the BASC teacher reported measure (Reynolds & Kamphaus, 1998). The results showed that the behaviour of children in the participating group improved from pre-test to post-test, as evidenced by a small effect size of $d=0.24$ for *Externalising Problems* and a moderate effect size of $d=0.46$ for the *Behaviour Symptoms Index*. Between the group comparison effect sizes for the same subscales were small: $d=0.24$ for *Externalising Problems* and 0.19 for the *Behaviour Symptoms Index* (Table 3).

Table 3

Studies of Child Centred Play Therapy (CCPT) Delivered by Teachers

Author and year	Participants' age and number (N)	Measures	Intervention name, place and duration	Who delivered	Other significant people involved	Effects
1. Helker and Ray (2009)	Children: 3 to 4 years N= 19 (Experimental) N=13 (Active Control) Teachers: N= 12 (Experimental) N=12 (Active Control)	CBCL (Achenbach & Rescorla, 2000)	CCPT delivered at preschool three times per week 10 weeks 30-minute sessions	Teachers and aides	No	CCPT vs. Control C-TRF Externalising ES, <i>d</i> could not be calculated “Significant decrease in Externalizing Problems (Helker & Ray, 2009, p. 70).
2. Morrison & Bratton (2010)	Children: 1 ^{1/2} to 5 years N= 26 (Experimental) N=26 (Active Control) Teachers: N= 12 (Experimental) N=12 (Active Control)	CBCL (Achenbach & Rescorla, 2000)	CCPT delivered at preschool three times per week 10 weeks 30-minute sessions Conscious Discipline (Bailey, 2000) delivered at preschool, duration unknown	Teachers and aides Teachers and aides	No	CCPT pre- vs. post-C-TRF Externalising ES, <i>d</i> =0.87 CCPT vs. Control C-TRF Externalising ES, <i>d</i> =0.16

Author and year	Participants' age and number (N)	Measures	Intervention name, place and duration	Who delivered	Other significant people involved	Effects
3. Morrison, Bennett, & Bratton (2011)	Children: 3 to 4.11 years N= 12 (Experimental) N=12 (Active Control) Teachers: N= 11 (Experimental) N=11 (Active Control)	CBCL (Achenbach & Rescorla, 2000)	CCPT delivered at preschool three times per week 10 weeks 30-minute sessions Conscious Discipline (Bailey, 2000) delivered at preschool, duration unknown	Teachers and aides Teachers and aides	No	CCPT pre- vs. post-C-TRF Externalising ES, $d=0.83$ CCPT vs. Control C-TRF Externalising ES, $d=0.92$
4. Post, McAllister, Sheely, Hess, & Flowers (2004)	Children: 2.1-5.4 years N= 9 (Participating) N=9 (Control) Teachers: N= 9 (Participating) N=8 (Control)	BASC-TRS (Reynolds & Kamphaus, 1998)	CCPT delivered at preschool once per week for 7 weeks 30-minute sessions	Teachers	No	CCPT pre- vs. post-BASC-TRS Externalising ES, $d=0.24$ Behaviour Symptoms Index ES, $d=0.46$ CCPT vs. Control BASC-TRS Externalising ES, $d=0.24$ Behaviour Symptoms Index ES, $d=0.19$

Studies of Teachers' Perceptions of CCPT Training

In a follow-up, mixed method study, Hess, Post and Flowers (2005) aimed to find out the perceptions of eight teachers who had been trained in CCPT (Table 4). This study did not use any behavioural measures for children. Hess et al. (2005) conducted focus groups with teachers to gain insight into teachers' experience of the training. Questions that were explored with teachers during focus groups concerned the usefulness of the training, any difficulties associated with it and whether the training resulted in changes in the children's behaviour, and teachers' views of the children. The focus group sessions were then transcribed. Some of the themes which emerged were that the training helped teachers to find a better way of relating to children; the skills learned by teachers were implemented with children; teachers gained a better understanding of children's behaviour and; learned that children have a right to make choices and decisions and teachers found that some CCPT skills were difficult to implement because other children needed attention at the same time. In addition, one teacher commented that her view of herself had changed as the result of the training (Hess et al. 2005).

Edwards, Varjas, White, and Stokes (2009) used a qualitative approach to evaluate teachers' perceptions of CCPT training in terms of its acceptability, integrity and effectiveness (Table 4). Five teachers participated in the CCPT training, which involved a two-day training period consisting of short lectures, group discussions, role-plays and discussing video vignettes. During the first day of the training teachers were taught how to describe a child's actions, techniques of empathy, limit-setting and encouragement. The second training day involved practising the skills and reviewing the training content. Following the training, teachers were asked to select a child with whom they would implement CCPT strategies and to work with a child with whom they had had difficulty building a relationship. Each teacher delivered individual 20-minute CCPT sessions with their target child once per week for 4 weeks.

Edwards and colleagues (2009) analyzed three data sources, including pre- and post-training semi-structured interviews, teachers' first and last audio-recorded supervision sessions and reflective journals with researchers' thoughts, comments and observations related to teachers' acquisition of CCPT strategies. As a result of the analysis, six major themes emerged: understanding of the content of the training, teachers' opinions regarding training structure, communication, the teacher-child relationship and views of the target child, and classroom management. The results showed that teachers viewed CCPT training as acceptable and effective and implemented CCPT strategies with all children in their classroom, not only their target children. The teachers reported a reduction in negative behaviour and a more positive classroom atmosphere and said that their interactions with children became more child focused which in turn, resulted in warmer teacher-child interactions and facilitated the development of social, language and academic skills. Some difficulties encountered by teachers during the training were learning to describe children's actions and emotions rather than ask questions; some challenges with allowing the child to lead in play; and the intensity of the training (Edwards et al., 2009).

In a similar study, Sepulveda, Garza and Morrison (2011) examined the perceptions of Head Start teachers who received CCPT training (Table 4). The authors applied a phenomenological methodology to analyse views of 10 early childhood and pre-kindergarten teachers in Head-Start programmes. During the 10-week training, teachers were taught foundational CCPT skills, such as reflective listening, describing and responding to a child's emotions, promoting self-esteem and creativity, and limit setting. Each teacher selected a target child from their preschool, who had the at-risk or *clinical* scores on the C-TRF (Achenbach & Rescorla, 2000). Target children received individual sessions, 30 minutes in duration, once per week for 7 weeks.

To gather insights from teachers, Sepulveda et al. (2011) used a semi-structured format of open-ended questions. Questions were used as prompts to generate a discussion about the teachers'

experience of the training. The themes which emerged were related to an improvement in the child-teacher relationship; positive changes in children's behaviour; enhanced confidence in classroom management; and the value of the facilitators. A non-affirming theme of scheduling problems also emerged as, during the training, teachers had the traumatic experience of living through a devastating hurricane. Even though some of the teachers' homes were severely damaged by this hurricane, the teachers expressed enthusiasm about their participation in the training and found it beneficial and worthwhile. Teachers reported that CCPT training helped them to better understand the children and increased their empathy towards them. Some teachers reported that they became more connected with the children and that "actual bonding took place" (Sepulveda et al., 2011, p. 20). Many teachers found that the training helped them regain a sense of control in their behaviour management skills and increased their ability to cope with difficult situations. Other important benefits included children's improved language, concentration, social and academic skills.

Table 4

Studies of Teachers' Perceptions of Child Centred Play Therapy (CCPT) Training

Author and year	Participants' number (N)	CCPT Training Protocol	CCPT Delivered to Children (place, duration)	Other significant people involved	Results
1. Edwards, Varjas, White, & Stokes (2009)	N=5	2 day training: 1 st day: skills in describing child's actions, empathy, limit-setting and encouragement. 2 nd day: practice and review.	CCPT delivered at school/preschool once a week 4 weeks 20-minute sessions	No	Key CCPT benefits: -improved behaviour in children; -improved teacher-child relationship; - enhanced classroom management skills in teachers.
3. Hess, Post, & Flowers (2005)	N=8	10-week training	CCPT delivered at preschool once per week for 7 weeks 30-minute sessions	No	Key CCPT benefits: -improved ways of relating to children; - better understanding of children and their behaviour; -teachers letting children make own choices and decisions; One teacher: transformed view of herself as the result of the training.

Author and year	Participants' number (N)	CCPT Training Protocol	CCPT Delivered to Children (place, duration)	Other significant people involved	Results
2. Sepulveda, Garza, & Morrison (2011)	N=10	5 weeks of training: reflective listening, describing and responding to a child's emotions, promoting self-esteem , encouraging creativity, and limit setting.	CCPT delivered at preschool once a week 7 weeks 30-minute sessions	No	Key CCPT benefits: -improved child-teacher relationship; -positive changes in children's behaviour; -enhanced confidence in classroom management with CCPT strategies.

Behavioural Interventions for Addressing Conduct Problems

For the purpose of showing that CCPT may be a good alternative to the more common behavioural type of interventions, several studies of typical behavioural techniques for conduct problems are reviewed in this section. Effect sizes have been calculated for main behaviour measures according to Cohen's (1988) guidelines. Given that no single subject studies of CCPT could be located in data base searching, and, in order to provide a basis for comparison, four single subject studies of behavioural interventions for children with conduct problems in early childhood settings have been also analysed. A percent non-overlapping data (PND), based on an extended celeration line, has been used to estimate effect sizes for these studies (Parker, Vannest & Davis, 2011). In this method, a PND of less than 50% is the equivalent of poor or negative effects, PND of 50%-70% is the equivalent of minimal effects, and PND above 70% is the criteria for an effective intervention (Parker et al., 2011).

The study by Diken and Rutherford (2005) evaluated the effectiveness of the First Step to Success (FSS) (Walker et al., 1998). FSS is a combined home and school behavioural intervention which involves parents working in partnership with the school to teach their child appropriate behaviour. Children for this study were referred by their teachers as being at-risk of developing antisocial behaviour. The children's parents and their teachers (N=4) also participated in the study. During the intervention, FSS was implemented in the children's homes and at school. For teachers, this involved two-hours of FSS training and a booklet outlining common issues associated with the programme implementation within the classroom. The children's parents were provided with information on FSS and their responsibilities were explained along with how to design a reward system for their children at home. The study used *Modified Parten's Social Play Scale* (Parten, 1932), *Revised Behavior Problem Checklist* (Quay & Peterson, 1996), *Teacher Ratings of Behavior* (Perkins-Rowe, 2001) and interviews with teachers and parents to evaluate the effects of the

programme. Teacher and parent ratings showed improvements in the child's problem behaviour and decreases in *Conduct Disorder* subscales. All teachers, except one, stated that the programme was successful for all children, including their target children. They also commented that they liked the idea of focussing positive attention on children's appropriate behaviours and they also liked learning about providing immediate praise. Parents reported that they found FSS effective and that it worked well with their children. The Percent Non-Overlap scores (Parker et al., 2011) calculated for *Modified Parten's Social Play Scale* non-social play behaviour showed that the intervention was ineffective for one child (PND=36%), minimal for a second child (PND=64%) and effective for two children (for both, PND=100%)

LeBel, Chafouleas, Britner and Simonsen (2012) used a different set of behavioural techniques to to reduce disruptive behaviour in four preschoolers. In their study, two preschool teachers were trained in a daily report card programme and then delivered this intervention in their classrooms with target children. During the intervention, teachers used a daily report card to rate each child's behaviour three times a day. They shared these ratings with children and their parents and provided contingent reinforcement which consisted of positive praise and stickers. LeBel et al. (2012) used direct observation of disruptive behaviour using partial interval recording in a single-subject design. Overall, parents and children found the intervention highly beneficial in terms of its acceptability, understanding of the intervention procedures, and its feasibility. The PND analysis indicated that the intervention was minimally effective for one child (PND=50%), and effective for three children (PND = 82%, 92% and 100%, respectively).

Han, Catron, Weiss and Marciel (2005) studied the effects of the pre-kindergarten RECAP programme (Han, 2001; Weiss, Harris, Catron, & Han, 2003) on children's behaviour problems and social skills. Throughout the schools year, one day per week, teachers were trained in RECAP by programme consultants. Topics covered in the training included: recognising the reasons for

children's behaviour; promoting structure and expectations in the classroom; ways to reinforce children's behaviour; consistent and fair discipline; communication skills; parent-teacher communication and modelling problem-solving to children. During the training time, teachers were implementing the RECAP strategies in their classrooms. Children, aged 4 to 5 years, were participants in this study; 83 children were assigned to the treatment group and 66 to the comparison group which received no intervention. The programme also had a parent training component for parents of children in the treatment group which involved 16 group bi-weekly sessions delivered at the school. CBCL and C-TRF (Achenbach & Rescorla, 2000) were used as behavioural measures. Teacher ratings showed that the pre- and post-effect sizes of the treatment group were $d=0.15$ for the *Total Problems*, $d=0.21$ for *Externalising Problems* and $d=0.13$ for *Aggressive Behaviour*, indicating a small effect. Effect sizes calculated between the two groups were $d=0.26$ for *Externalising Problems* and $d=0.28$ for *Aggression* (moderate effect). Effect sizes for *Externalising Problems* and *Aggression*, according to parent ratings, were in the small range.

In the study by Hutchings, Bywater, Daley and Lane (2007b), the Incredible Years Classroom Dinosaur School Programme (Webster-Stratton & Reid, 2003) was evaluated. Nine children, aged 7 to 9 years, diagnosed with conduct disorder, participated in weekly two-hour group sessions for approximately 22-weeks. Sessions were delivered by two trained group leaders. During the sessions children learned how to make friends, cooperate with peers, follow school rules, problem-solve and recognise feelings. Group leaders encouraged children's learning by praising and rewarding appropriate social skills and by labelling these skills. Hutchings et al. (2007b) used SDQ (Goodman, 1997) completed by teachers and the *Self-Control Rating Scale* (SCRS) (Kendall & Wilcox, 1979) to measure changes in children's behaviour. The mean SDQ scores at pre-intervention were 20 and SCRS were 163 and were in the *clinical* range. Post-intervention SDQ scores improved from the *clinical* to the *borderline* range and SCRS scores improved to below the

clinical level. The total SDQ scores decreased by 7 points and the effect sizes for SDQ scores were large: $d=1.8$ and $d=1.5$.

Hutchings, Lane, Owen and Gwyn (2004) studied the effects of the same programme on five kindergarten and two year-one children with conduct problems. In this study, the Incredible Years Classroom Dinosaur School Programme (Webster-Stratton & Reid, 2003) was delivered during the school year and lasted approximately nine months. SDQ (Goodman, 1997) was used as one of the measures of the children's behaviour. The authors also conducted interviews with parents and teachers to gain their perceptions of the programme. The results showed that the SDQ scores of two children reduced from *clinical* to *normal* levels. Of the parents interviewed, five said that they had observed noticeable improvements in their children's behaviour, including enhanced social skills, self-control and ability to take turns and negotiate. Teachers reported similar results adding to parents in that children also learned how to use new skills in different situations and contexts.

Larmar, Dadds and Shochet (2006) tested the effectiveness of another programme, called the Early Impact (EI) (Larmar, 2002) which is a preventative programme designed for prevention of the childhood conduct problems and incorporates school and home components. The school component includes training teachers and teacher aides in behaviour management techniques based on the EI manual. The teachers received one-day training followed by an intensive training over 10 weeks. The home component was a three-session parent training which covers examination of parental practices, child development, household rules, reinforcement consequences, problem-solving and some other topics. The participants of the study were 455 children, aged from 4 to 5 years, enrolled across 10 preschools and 72 parents and teachers. Prior to the intervention, children were screened for conduct problems and following this, 66 children were assigned to the intervention group and 69 to the control. The EI was delivered to the children over a 10-week period. Children in the comparison group received no interventions but their parents were informed that they could

participate in the following year. Among other measures, the study used the parent and teacher versions of SDQ (Goodman, 1997). The teachers' results showed that scores at pre-intervention were within the *clinical* range for conduct problems (7.33) and for *Hyperactivity* (10.03). At follow-up, *Conduct Problems* reduced by one point and *Hyperactivity* scores reduced by two points which left the scores in the *clinical* threshold. Similarly, parent ratings showed small reductions in *Conduct Problems* and *Hyperactivity* scores, leaving the scores in the *clinical* range.

Summary

Reviewing the existing literature on CCPT, it becomes clear that CCPT may be beneficial for children with conduct problems by enhancing the skills of their early childhood teachers. Teachers generally find CCPT training useful and worthwhile and the effect sizes for teachers are larger than the effect sizes for play therapists. This may be because teachers see the children more frequently, and, even if they do not deliver individual sessions, they may interact with them during the day in different ways due to training. In addition, studies of behavioural interventions for children with conduct problems in early childhood settings show that behavioural strategies produce smaller or similar effects, as compared with CCPT. This may indicate that CCPT can be a possible alternative to common behavioural interventions. However, a lack of data showing the pathways of individual change, as shown in single subject designs, indicates an area for further research. Therefore, the goal of this pilot study was to explore whether young children who have persistent conduct problems in early childhood settings in New Zealand would show improved behaviour following their early childhood teachers learning some play-therapy strategies. It also aimed to gather information from teachers about the suitability of play therapy strategies within the context of the New Zealand early childhood system.

The methodology for a single subject investigation of CCPT is described in Chapter 3.

Chapter 3 Methods

Research Design

A mixed method, single subject and qualitative descriptive design was used in the current study.

An A-B1B2-C single-subject design replicated across behaviours and across children was employed. The phases of the study for were baseline (A), teacher training (B1), CCPT intervention delivered by teachers (B2), and follow-up (C). The qualitative descriptive component involved recording teachers' comments and reflections during phases A, B1, and B2 and then gaining teacher feedback in an interview using open-ended questions and a questionnaire during Phase C, which were then transcribed and analysed.

According to Ray and Schottelkorb (2010, p. 51), single-subject design can be “a viable research design option for play therapist researchers” as it can be utilised without access to extensive financial or human resources. Yet single-subject design offers practitioners a legitimate design allowing establishing empirically validated treatments and evidence-based practices (Rapoff & Stark, 2008; Ray and Schottelkorb, 2010). The advantage of using a qualitative descriptive design when studying a limited number of cases in depth is that the data are based on the participants' own categories of meaning, not on the researcher's pre-conceived ideas (Denzin & Lincoln, 2005).

A mixed research method design has two main advantages as outlined by Patton (2002). First, it permits the researcher to assess individualised outcomes of a programme and see whether it meets individual needs. Second, it allows the researcher to learn how and the extent to which a programme was actually implemented. Finally, the use of mixed research methods to study a programme can lead to study findings being given more depth.

Human Ethics Approval

Before commencing participant recruitment, ethics approval for the study methodology and for the processes of participant recruitment and informed consent were obtained from the University of Canterbury Education Human Ethics Committee. A copy of the letter from the University of Canterbury Education Human Ethics Committee with the approval can be found in Appendix A. Approved consent forms for the centre manager, teachers and parents can be found in Appendices B and C.

Recruitment and Teacher Consent Process

The kindergarten manager was approached in person by the researcher and given an information sheet about the study. With the approval of the manager, the researcher contacted the kindergarten by telephone and arranged a meeting to explain the study to the team members. At the meeting, the researcher discussed the study in detail and answered teachers' questions using the information sheet as a basis for the discussion. This was followed by a telephone call in two days to ask whether the teachers were interested in participating in the study. All five teachers agreed to participate in the study. However, the study was limited to two participants and therefore, only two teachers signed the consent forms.

Inclusion and Exclusion Criteria

The researcher then met with the consenting teachers to discuss children who, the teachers felt, would be most likely to benefit from the strategies (the CCPT strategies were previewed). Children were considered for inclusion in the study if they had behavioural difficulties and attended three or more sessions a week. The exclusion criteria were receiving early intervention behavioural services, or having a disability. The teachers nominated two children who were eligible for participation by meeting the above requirements.

Child and Parent Informed Consent

Once the teachers nominated the children, the kindergarten supervisor sent an information sheet and consent form home to the nominated children. The parents and children were able to meet the researcher at the kindergarten to discuss the study and have their questions answered. The parents were asked to discuss the study with their child or read the study protocol.

Setting

The setting for the study was a privately owned kindergarten located in the Canterbury region catering for around 30 children aged between 3 and 5 years and staffed by five teachers. The kindergarten was located in a residential area in the grounds of a primary school, serving professional/working middle-class families.

In 2010, the New Zealand Government's Education Review Office (ERO) visited the kindergarten and conducted a review of the service. The report (ERO, 2010) noted that the teachers had difficulties managing the children's behaviour. In particular, the teachers' responses to children whose behaviour breached the kindergarten rules were often negative and inconsistent. ERO also reported that some teachers did not recognise the importance of being flexible and changing aspects of the curriculum or environment to better respond to the children's behaviour. It was noted that the teachers did not fully utilise difficult situations to help the children learn how to resolve their own problems and take responsibility for their own behaviour. Therefore, it was recommended that the service needed "to develop a more consistent and effective approach to help children manage their behaviours successfully" (ERO, 2010, p. 2).

Participants

All participants of the study have been given pseudonyms to maintain confidentiality. Throughout the study the teachers are referred to as Cathie and Lee, the children are referred to as Peter and Tui.

Characteristics of teachers. A questionnaire form was created and used in an interview with the teachers to collect demographic information from them, including age, gender, ethnicity, primary language, educational background, years of teaching experience, and beliefs about the importance of addressing behaviour problems in children (Appendix D).

Cathie. Cathie, aged in her forties, is a registered New Zealand European female teacher, who has been employed at the kindergarten for more than five years. She holds a three-year Diploma of Early Childhood Teaching and has been teaching for eight years. In the questionnaire section regarding respondents' beliefs about the importance of addressing behaviour problems, Cathie wrote that timely prevention of behaviour problems helps children eliminate unacceptable behaviour and "develops ideas of fairness and justice" as well as helping with the development of social skills.

Lee. Lee is also aged in her forties and a New Zealand European. She has been employed at the kindergarten for two years as a registered early childhood teacher. She holds a two-year Graduate Diploma in Teaching and has been teaching for three years. She wrote that it was important to address behaviour problems, as "it helps children to discover ways to improve all areas of their lives" and maintain positive relationships with people around them.

Characteristics of the children. A brief questionnaire was designed to collect demographic information on the children. The information was collected by teacher report and included questions on the child's age, gender, ethnicity, and language(s) spoken at home (Appendix E).

Peter. Peter, aged 4, a New Zealand European boy, had been attending the kindergarten for two years, and attended three full days per week during the study period. Teachers reported that Peter had a tendency to physically attack other children. They also had concerns about Peter's frequent temper tantrums, noncompliant behaviour, and his extreme difficulty in forming relationships with other children. Cathie reported that these behaviours were accompanied by Peter

“getting other children to do things that he knows is not the right behaviour and to see them get into trouble.”

Tui. Tui, a 4-year old bilingual Māori boy, had been attending the kindergarten for 18 months. He attended five full days a week. Teachers expressed concerns that, although Tui was interested in other children and seemed to want to make friends, his frequent attempts to play with the children were rarely successful as he would often initiate a contact by aggressively grabbing away their toys, knocking down or pushing over their creations or dumping peers' materials on floor. Lee also commented that Tui would often “stare down” other children and even teachers to “get his own way”.

Measures

Strengths and Difficulties Questionnaire (SDQ). This brief 25-item inventory is designed as a behavioural screening instrument to assess the occurrence of behaviours associated with emotional symptoms, hyperactivity, peer relationships, and conduct problems in 3-16 year old children (Goodman, 1997; Goodman, 2001) (Appendix F). This scale was completed for each child at the beginning of baseline and during follow-up. Cathie completed the SDQ for Peter and Lee completed for Tui.

SDQ is considered to be an extensively validated measure as its scores highly correlate with other established measures of child behaviour, such as Rutter questionnaires (Elander & Rutter, 1995), and the longer Child Behavior Checklists (CBCL) (Achenbach, 1991a,b,c) which are widely applied in epidemiological studies and clinical practice (Goodman, 2001; Mellor, 2004).

SDQ is acceptable in New Zealand, and forms part of the regular schedule of national screening provided by the Ministry of Health (Neale, 2012). In regard to discriminate validity, high SDQ scores have been found to be associated with a marked increase in psychiatric risk in children

(Goodman, 2001). The evidence presented by Warnick, Bracken and Kasl (2008) in meta-analysis of 29 studies provides further support for the use of the SDQ in clinical and educational settings.

The SDQ forms were scored following the standard protocols in Australian English, where items are scored 1 for “Somewhat True” and the scoring for “Not True” and “Certainly True” may be scored as 0 or 2. A *Total Difficulties Score* can range from 0 to 40 and is generated calculating the sum score of all the scales, excluding the prosocial scale (Scoring the informant-rated SDQ, 2012). The scores were interpreted using the clinical cut-off levels for Australia, published on the sdq.info website (Scoring the informant-rated SDQ, 2012).

Play Observation Scale (POS) (Rubin, 2001). The scale uses a time-sampling format to individually measure a child’s play behaviour during free-play activities (Appendix G). POS has been utilised extensively in studies of socio-emotional development and play and has been demonstrated to be a reliable and valid instrument to measure child play behaviour (e.g., Fox et al., 1995; Kennedy-Behr, Mickan, & Rodger, 2011; Langevin, Packman, & Onslow, 2009).

The POS was used as a repeated measure of play during baseline, implementation of CCPT, and follow-up phases. The play of the nominated children was recorded on the POS twice a week during free play activities (times in which the child had the maximum opportunity to engage with others). The observations were conducted while staying close to the child, but not interfering with their activities or, engaging with them, other children or teachers in any way. During the observations, teachers were asked to interact with the children and respond to them as they normally would. Play behaviours that occurred within a 10-minute observational period were recorded following the standard administration.

The POS was scored for each observation following standard procedures. The total number of positive play behaviours and the total number of problem behaviours observed were graphed

following standard single-subject protocols. A percent non-overlapping data, based on an extended celeration line, has been used to estimate effect sizes (Parker et al., 2011).

Teacher satisfaction questionnaires. As part of evaluating the social validity in the current study, teachers completed the Teacher Satisfaction Questionnaire (Appendix H) at the end of the follow-up. Social validity was assessed in three areas, according to Turan and Meadan's (2011) guidelines: "(a) the social significance of the goals or the importance of the goals for society; (b) perceptions of the social appropriateness, or acceptability, of the intervention procedures by consumers (e.g., families and teachers); and (c) consumers' perceptions of the social importance of the intervention effects or their satisfaction with the intervention outcomes" (p. 15). The questionnaire included questions regarding teachers' experience in delivering the CCPT strategies, overall satisfaction with the effects of the strategies, and possible changes that could improve the delivery of the CCPT training. In addition, throughout the study, teachers were providing verbal feedback regarding their experiences of implementing CCPT. They gave their consent for the feedback to be included in the study.

Teacher interviews. After completing the questionnaires, teachers participated in an individual interview session where they were invited to clarify and elaborate on their questionnaire responses. The interviews, 30 to 60 minutes long, were held in the centre's staffroom.

The aim of the interviews for the current study was to gain teachers' perspectives, views and themes about the CCPT training in their own words. Lofland and Lofland (1994) suggest that an interview can be seen as a "guided conversation whose goal is to elicit from the interviewee rich, detailed materials that can be used in qualitative analysis" (p.18). Consistent with the studies by Edwards et al. (2009) and Sepulveda et al. (2011), a semi-structured format of open-ended questions was used. The interviews were audio digitally recorded and transcribed.

Procedures

Baseline. The participant children were observed for 10 minutes twice a week prior to the CCPT training. During this period, teachers continued using behaviour management and play processes as usual.

Teacher training. The teacher training phase included two stages of teacher training. Stage I covered theory and basic CCPT strategies and Stage II focused on integration and application of these strategies in an early childhood setting. Training was based on the *Child-Centered Play Therapy Treatment Manual* (Ray, 2011b). For the purposes of this study, the CCPT treatment protocol was specifically adapted to design a concise curriculum for early childhood teachers with a focus on the child-teacher relationship and linked with Te Whāriki, the New Zealand early childhood curriculum (Ministry of Education, 1996). The training content is described in detail in Chapter 3.

Stage I involved three-hour CCPT training sessions scheduled over two consecutive days. The sessions were delivered to two teachers at the premises of the University of Canterbury Health Sciences Centre. Stage II of training began on the next day following Stage I, and included 20 minutes of in-centre coaching by the researcher. During this stage the researcher provided immediate feedback to a teacher delivering CCPT strategies to a child via bug-in-ear technology.

The CCPT training was delivered by the researcher, who has completed an introductory CCPT course in New Zealand and an advanced highly skill-based play therapy course. The researcher is a trained early childhood and early intervention teacher and holds a full registration as an early childhood teacher with the New Zealand Teachers' Council. The researcher's training also includes a postgraduate qualification in Health Sciences endorsed in Early Intervention.

CCPT intervention. During this phase, teachers were asked to implement the trained strategies. The CCPT Intervention phase involved teachers delivering CCPT strategies to their target child in individual 15 minute sessions twice per week for 8 weeks within the kindergarten environment.

The sessions were 15-minutes in duration and were conducted twice weekly at about the same time each day. The teachers were able to schedule sessions to fit within their responsibilities and the centre's schedule. Teachers selected the time to conduct sessions so that they were unlikely to be interrupted; another staff member was available if help was needed. Toys which were suitable for CCPT were identified by the teachers during training and kept ready for the session (e.g. craft materials, sand, real-life toys and aggressive toys).

Coaching and feedback was available to teachers on request. During coaching and informal meetings with teachers, their comments about the CCPT were recorded. Child observations occurred twice a week during free play periods.

Follow-up. This phase began at the conclusion of the CCPT intervention. Direct child observations continued for 2 weeks on the same schedule.

Chapter 4 Teaching Early Childhood Teachers Child Centred Play Therapy Strategies: A Manual for Trainers

This chapter presents the curriculum delivered to teachers during Stage I of the teacher training phase. The manual was written for the purposes of the present study by the researcher, and delivered by the researcher during the pilot study. The manual consists of two parts: the first part is an introduction to what CCPT is and presents a discussion of the linkages and relationships between CCPT and *Te Whāriki* (Ministry of Education, 1996); the second part of this manual provides practical CCPT strategies for teachers. The final part has the session outlines of the training the teachers received.

Early Childhood Teachers Using Play Therapy Strategies

Early childhood teachers are significant people in children's lives (Draper et al., 2001; Morrison & Bratton, 2010). This places them in a good position for implementing child centred play therapy strategies which may help to promote children's social skills and reduce behaviour problems. The concept of child centred play forms a basis for Te Whariki - the New Zealand early childhood curriculum (Alvestad, Duncan, & Berge, 2009; White et al., 2010) which makes child centred play therapy strategies particularly relevant to the New Zealand early childhood context. Te Whariki views child centred play "as meaningful learning" and emphasises the importance of spontaneous and creative play experiences in children's holistic learning and development (Ministry of Education, 1996, p. 82). It encourages teachers to create an environment based on consistent and warm relationships where children can freely express themselves through play which enhances their sense of identity, self-esteem, confidence, and enjoyment (Ministry of Education, 1996). Similarly, the goal of CCPT is to facilitate the development of positive adult-child relationships through play to promote children's self-confidence, self-responsibility, self-direction, independent decision making, and internal self-assessment (Ray, 2011b). Given close links between Te Whariki (Ministry

of Education, 1996) and CCPT, early childhood teachers may consider the feasibility and potential benefits of incorporating some of these strategies for the use in early childhood settings.

The Concept of Child Centred Play Therapy

Garry Landreth (2011), a renowned play therapy author and researcher, believes that “child-centered play therapy is an attitude, a philosophy, and a way of being with children rather than a way of doing something to or for children” (Landreth, 2011, p. 60). CCPT has a unique philosophy that views children as individuals capable of positive self-direction. Ray (2011b) developed a metaphor to portray this unique philosophy where “children are seen as flowers to bloom, not clay to be shaped” (p. 5). Flowers blossom when favourable conditions are provided and they wilt when there is not enough sun, water and food. Clay, in contrast, may be modelled, poked and scraped to produce a desired shape and the initial shape of the clay is lost and not important. Similarly, CCPT does not aim to reshape the child’s life or change the child in a particular way but provides conditions for emotional growth and constructive change. In CCPT, it is the warm and accepting relationship that makes a difference and brings a therapeutic effect (Landreth, 2011; Ray, 2011b).

Child Centred Play Therapy: What Children Learn and How It Links to *Te Whāriki*

CCPT may be particularly suitable for use by New Zealand early childhood teachers due to its similarity to the New Zealand early childhood curriculum, *Te Whāriki* (Ministry of Education, 1996). The first similarity is that the concept of child centred play forms a basis for *Te Whāriki* (Alvestad et al., 2009; Ministry of Education, 1996; White et al., 2010). *Te Whāriki* emphasizes the importance of child centred play for successful learning, and views children’s “own experiences, knowledge, skills, attitudes, needs, interests, and views of the world” as a basis for the curriculum (Hedges, Cullen, & Jordan, 2011; Ministry of Education, 1996, p. 40). Similarly, in CCPT, play forms the core of the therapy and provides a means through which a therapeutic working relationship with the child is established. The therapist joins the child’s play as a follower,

constantly following the child's feelings, ideas and interests (Ray, 2011b). It is possible that the centrality of play in both CCPT and *Te Whāriki* (Ministry of Education, 1996) can make this type of play therapy especially relevant to the early childhood context of Aotearoa New Zealand.

The second reason for using CCPT in New Zealand early childhood settings is that both *Te Whāriki* (Ministry of Education, 1996) and CCPT view child centred play as a valuable learning experience for children. Garry Landreth (2011, p. 89), play therapy renowned author, believes that child centred play therapy is “a unique learning experience” in which children develop new skills “under the most favourable growth-promoting conditions possible”. *Te Whāriki* (Ministry of Education, 1996), in turn, views child centred play “as meaningful learning” and emphasizes the importance of spontaneous and creative play experiences in children's holistic learning and development (Ministry of Education, 1996, p. 82). The curriculum encourages teachers to create an environment based on consistent and warm relationships, where children can freely express themselves through the medium of play that enhances their sense of identity, self-esteem, confidence, and enjoyment (Ministry of Education, 1996). Similarly, Ray (2011a) states that the goal of CCPT is to facilitate the development of positive adult-child relationships through play to promote children's self-confidence, self-responsibility, self-direction, independent decision making, and internal self-assessment.

Thirdly, CCPT may be considered a potentially culturally sensitive intervention that may be suitable for use with Māori tamariki and whānau. *Te Whāriki* (Ministry of Education, 1996) is a bicultural document that incorporates Māori knowledge and perspectives (Ministry of Education, 2004). It values the cultural background of the child and the child's community. This is consistent with the philosophy of CCPT, where children's uniqueness is respected and all children are unconditionally accepted for who they are (Landreth, 2002; 2011; Ray, 2011a,b). Although to date there are no studies investigating the cultural appropriateness of CCPT for use with Māori tamariki, the field of

play therapy has a long history of working with culturally diverse populations (Penn & Post, 2012).

For this reason, CCPT is unlikely to contradict Māori family values and traditions.

Table 5 below provides a visual comparison between the goals of *Te Whāriki* (Ministry of Education, 1996) and the goals of CCPT.

Table 5

Comparison between the Goals of Te Whāriki (Ministry of Education, 1996) and the Goals of CCPT

<i>Te Whāriki</i>	Child centred play therapy
<p>Strand 1: Well-being – Mana Atua</p> <p>Children experience an environment where:</p> <ul style="list-style-type: none"> • their health is nurtured; • their emotional health is promoted; • they are safe (Ministry of Education, 1996). 	<p>Child centred play therapy creates a safe environment where:</p> <ul style="list-style-type: none"> • children learn to take responsibility for their own well-being; • their emotional well-being is promoted; • an atmosphere of safety is created by a consistent and accepting adult (Landreth, 2011; Ray, 2011b).
<p>Strand 2: Belonging – Mana Whenua</p> <p>Children and their families experience an environment where:</p> <ul style="list-style-type: none"> • connections with their family and community are affirmed and built on; • they know that they belong; • they feel comfortable with events and routines; • they are familiar with boundaries of acceptable behaviour (Ministry of 	<p>Child centred play therapy creates a safe environment where:</p> <ul style="list-style-type: none"> • children's uniqueness is respected and they are unconditionally accepted for who they are; • they know they can explore and express themselves in many different ways; • they feel secure and familiar with the environment of the play room and the

<i>Te Whāriki</i>	Child centred play therapy
Education, 1996).	<p>structure of play sessions;</p> <ul style="list-style-type: none"> consistent limits are established which creates an atmosphere of predictability and security (Landreth, 2011; Ray, 2011a,b).
<p>Strand 3:</p> <p>Contribution – Mana Tangata</p> <p>Children experience an environment where:</p> <ul style="list-style-type: none"> irrespective of their ethnicity, gender, ability, age or background they have equitable opportunities for learning; their individuality is affirmed; learning with and alongside others is encouraged (Ministry of Education, 1996). 	<p>Child centred play therapy creates a safe environment where:</p> <ul style="list-style-type: none"> children are equally warmly accepted by the therapist, regardless of their background and other aspects of their life; they are affirmed as unique and worthy of respect, with individual personality and will; they explore relationships, learn to cooperate and their social competence is promoted (Landreth, 2011; Ray, 2011a,b).
<p>Strand 4:</p> <p>Communication – Mana Reo</p> <p>Children experience an environment where:</p> <ul style="list-style-type: none"> they learn how to communicate non-verbally for a range of purposes; they develop verbal communication skills; stories and symbols from their own and other cultures are present; they master diverse ways of being 	<p>Child centred play therapy creates a safe environment where:</p> <ul style="list-style-type: none"> children develop the ability to communicate their feelings and emotions through play (either verbally or non-verbally); they explore toys and books which represent different cultures discover and explore different media of creative expression (Landreth,

<i>Te Whāriki</i>	Child centred play therapy
creative and expressive (Ministry of Education, 1996).	2011; Ray, 2011a,b).
<p>Strand 5: Exploration – Mana Aotūroa</p> <p>Children experience an environment where:</p> <ul style="list-style-type: none"> • play is viewed as meaningful learning and spontaneous play is encouraged; • they learn to use their bodies confidently; • they master different exploration, thinking, and reasoning strategies; • they develop their own theories about natural, social, physical, and material worlds (Ministry of Education, 1996). 	<p>Child centred play therapy creates a safe environment where:</p> <ul style="list-style-type: none"> • play is recognised as natural language for children and “the medium of self-expression with which they are most comfortable” (Landreth, 2011, p. 54); • children develop and exercise a sense of control through play (Ray, 2011b); • they learn to be creative and problem-solve when confronting difficult situations (Landreth, 2011; Ray, 2011b); • through play children make sense of different parts of their world (Landreth, 2011; Ray, 2011b).

The first strand of *Te Whāriki*, Mana Atua (well-being), encourages teachers to create an environment which promotes children’s health, nurtures their emotional well-being and ensures safety (Ministry of Education, 1996). The strand recognises the importance of consistency and continuity of young children’s experiences, and the need to provide these for children to help them develop confidence and trust essential for successful learning and exploration (Ministry of Education, 1996). Teachers are encouraged “to establish a secure foundation of remembered and

anticipated people, places, things, and experiences” (Ministry of Education, 1996, p. 46). In CCPT, children’s health and their emotional well-being are also nurtured and promoted by the therapist through the entire process of play therapy. Landreth (2011) and Ray (2011a) believe that when children are involved in play therapy sessions they develop essential social skills, emotional literacy, ability to self-regulate, and learn how to concentrate and problem-solve in difficult situations. For example, to encourage the development of problem-solving in the child, the therapist avoids doing for the child what they can do for themselves. Instead, the child is warmly encouraged to find a solution on their own if it is clear that the child is capable of doing the action themselves (Landreth, 2011; Ray, 2011b). By withholding help, the therapist stimulates the child’s own creative resources and helps the child experience the satisfaction and the sense of achievement of completing something by themselves. This process is believed to promote creativity and resourcefulness in confronting difficult social situations that could be overwhelming for the child (Landreth, 2011; Webster-Stratton & Reid, 2009).

A further link between the first strand of *Te Whāriki* (Ministry of Education, 1996) and CCPT is the importance of consistency and continuity. The goals of the Mana Atua strand emphasise promoting children’s well-being through teacher-child relationships characterised by consistency and warmth that helps the teachers to connect with the child (Ministry of Education, 1996). In an early childhood setting the environment of safety and continuity is also maintained through toys and activities being familiar to children and toys being kept in designated places. In CCPT, consistency and continuity are also given an important role and are considered to be therapeutic. It is believed that learning, risk taking and exploration in a play room can only happen in the context of safety, consistency and warmth created by the therapist: “the therapeutic process emerges from a shared living relationship developed on the basis of the therapist’s consistently conveyed acceptance of children and confidence in their ability to be of help to themselves, thus freeing children to risk using their own strengths” (Landreth, 2011, p. 83). The play therapist establishes an environment of

consistency and continuity through being consistent in their own attitudes and behaviour, through establishing consistent limits and boundaries in the play room, and the playroom's order and predictability (Landreth, 2011). The play therapy room is also consistent. Toys are always kept on their designated shelves, activities are presented in a particular side of the room, and the duration of the play session is always the same.

The second strand of *Te Whāriki*, Mana Whenua (belonging) emphasises the importance of connecting links with the child's family and community. According to *Te Whāriki*, children need to know that they have a place in their early childhood education centre and it is important that they feel comfortable and familiar with the routines and boundaries of their centre (Ministry of Education, 1996). CCPT also recognises and appreciates the importance of culture for the child's emotional growth and positive change (Association for Play Therapy, 2009; Baggerly, 2006; Garza & Bratton, 2005; VanderGast, Post, & Kascak-Miller, 2010). This is reflected in *Play Therapy Best Practices* guidelines published by the Association for Play Therapy (2009) which proclaim that play therapists should provide culturally sensitive interventions that would be appropriate for children and families from diverse cultural backgrounds. Play therapists are advised to deliver play therapy which affirms and maintains children's cultural identity.

Play therapists use a variety of strategies to create a culturally sensitive environment which appreciates and welcomes the culture of the child and their family. They modify their language, select culturally meaningful toys (Chang, Ritter, & Hays, 2005), incorporate the family's culture and experiences in the play therapy process, and use culture specific knowledge to build relationships with children and families (Hinman, 2003; Garza & Bratton, 2005). These strategies are believed to invite the child's interaction and promote a sense of belonging in young clients and their families (Klopper & Dachs, 2008; Landreth, 2011).

The third strand of *Te Whāriki* (Ministry of Education, 1996), Mana Tangata (contribution) recognises the importance of early childhood environments in which children of different gender, abilities, cultures and backgrounds have equitable opportunities for learning. This strand encourages teachers to respect children as individuals. The principles of this strand appear to be similar to those of CCPT. During the process of play therapy, the therapist maintains and communicates a consistently positive regard and respect to children, irrespective of their abilities, age, gender, background and behaviour (Landreth, 2011). Children may have tendencies to play passively or be aggressive in their play, or they may constantly ask the therapist for help. Whatever behaviour they display, it is believed that children should see the therapist's respect and experience acceptance as individuals. Such presence of constant acceptance and absence of evaluation is considered to help children to internalise the respect and learn to respect themselves. Once children have learnt to respect themselves, they develop respect for others (Landreth, 2011).

The Mana Tangata strand also encourages teachers to promote children's learning with and alongside other children and adults. This is consistent with CCPT. Although CCPT is not usually a group experience, play therapy promotes children's cooperation with peers through developing children's social capabilities, such as the ability to cooperate, self-regulate and build positive relationships with others (Landreth, 2011; Webster-Stratton & Reid, 2009). One of the ways the play therapist promotes these is through showing acceptance of the child's emotions and being responsive. As a result, children freely explore their thoughts and emotions (Landreth, 2011), learn vocabulary to express these emotions, and gain the ability to recognise and cope with them. When they become emotionally literate, they are more capable of expressing emotions in appropriate ways and can regulate their emotions more easily (Webster-Stratton & Reid, 2009). These CCPT processes promote the development of emotional self-regulation, the ability to empathise with others, accept limits and control their own behaviour.

Strand four of *Te Whāriki* (Ministry of Education, 1996), Mana Reo (communication) states that verbal and non-verbal ways of communication are promoted and there should be a commitment from teachers to recognise children's home language through stories, arts, crafts, and symbols. It promotes a holistic view of literacy where teachers may assist children in developing diverse ways of being creative and expressive through activities that are meaningful to children (Education Review Office, 2011). Similar ideas regarding fostering children's verbal communication underpin the CCPT. For example, one of the basic CCPT techniques is describing the child's behaviour. By doing this, the therapist conveys their acceptance of the child and communicates their interest in whatever the child is doing (Ray, 2011b). At the same time, this technique is found to be an effective approach in developing the child's language skills and addressing speech and language difficulties (Danger & Landreth, 2005; Purcell-Gates, Melzi, Najafi, & Orellana, 2011; Yoder, Molfese, & Gardner, 2011). It has also been suggested that CCPT may provide three important environmental conditions which are crucial for language learning, including opportunities for joint involvement, experiences that are meaningful for the child, and a natural context for verbal expression (Danger & Landreth, 2005). Therefore, focus on children's verbal communication is probably another common area that further solidifies links between *Te Whāriki* (Ministry of Education, 1996) and CCPT.

CCPT also links with strand four of *Te Whāriki* (Ministry of Education, 1996) through providing children with multiple opportunities to be creative and expressive and helping them to develop non-verbal ways of communication. Although, as discussed above, CCPT promotes the development of speech and language, in play therapy children are not restricted to verbal expression (Landreth, 2011). It is recognised that many children, due to their developmental level or abilities, may have considerable difficulties expressing their feelings and experiences through words, "but, if permitted, in the presence of a caring, sensitive, and empathic adult, they will show what they feel through the toys and materials they choose, what they do with and to the materials, and the story acted out"

(Landreth, 2011, p. 17). For this reason, CCPT rooms are often equipped with a variety of expressive toys, media and materials that allow non-verbal self-expression, creativity and emotional release.

Strand five of *Te Whāriki* (Ministry of Education, 1996) Mana Aotūroa (exploration) emphasises the importance of an environment where children's play is considered as meaningful learning, and which offers wide possibilities for spontaneous play. Such an environment should allow active exploration (including physical), thinking and reasoning; it should invite children to discover their own theories for understanding the world around them (Ministry of Education, 1996). Similar ideas regarding play and exploration may be found in CCPT. For example, CCPT views play as “a unique learning experience” in which children develop new skills “under the most favourable growth-promoting conditions possible” (Landreth, 2011, p. 89). Through being involved in spontaneous play, children engage in experiential learning about the self; they develop the ability to make choices, take risks, problem-solve, accept responsibility for themselves, and develop self-control. In play therapy, children are free to conquer challenges by themselves, come up with their own solutions and problem-solve. They develop their creative resources and reasoning and often become enthusiastic about finding answers and arriving at best solutions without being helped. Being creative is believed to help children develop their repertoire of actions and help to solve peer problems in positive ways (Landreth, 2011; Ray, 2011b).

CCPT Strategies

Strategy1: Prepare for the play session.

Set a time for the play session. Conducting play sessions at the same time each day helps the child to experience consistency and mastery over their environment (Ray, 2011b). Sessions should be 15 minutes in length and should be conducted twice a week for 8 weeks. It is understood, however, that conducting sessions at a scheduled time may not always be possible in a busy early

childhood environment. If this is the case, the teacher can find another time for the session by taking advantage of opportunities that arise throughout the day. Embedding sessions into free play activities will make play sessions a natural part of the daily programme.

It is recommended that sessions are conducted in times when teachers:

- are unlikely to be interrupted and/or be involved in other tasks (e.g., greeting parents, serving morning tea or tidying up);
- have an extra staff member available to provide support if needed;
- are relaxed, rested and able to devote individual attention to the child.

Consider characteristics of children. It is desirable that the teacher conducts a session with their target child individually as it takes time to develop CCPT skills necessary to work with a number of children effectively. Therefore, it is important to attempt group sessions only after the teacher has had a reasonable amount of time practicing play therapy strategies with their target child.

The teacher may choose to conduct a group play session when the target child is playing with another child who is a ‘safe play partner’, a child who is likely to be responsive and positive. This can help to avoid conflicts and power struggles and make the play session a safe therapeutic experience for the target child.

Select play materials. It is not necessary, nor practically possible, for the teacher to rearrange the centre environment for each play session. Some toys and materials offer more opportunities for self-expression by the child and interaction with the teacher (Landreth, 2011). Therefore, the child’s play with certain toys or materials may offer a unique opportunity for conducting an effective play session.

Expressive toys. Expressive toys and materials allow self-expression, creativity and emotional release. These may include art and craft materials, sand, clay, and water (Ray, 2011b). Paints provide the child with multiple opportunities to be creative and messy and to express positive and negative emotions. Sand and water are considered to be the most effective media for play therapy since there is no right or wrong way to play with them. Thus, whatever the child creates with sand and water is very likely to promote a feeling of achievement. These media convey acceptance and permissiveness and can be especially useful for shy or withdrawn children (Landreth, 2011). Therefore, the early childhood teacher may consider the potential benefits of conducting their play sessions in the sandpit or by the water trough.

Real-life toys. These toys may represent significant adults in the child's life and give the child the opportunity to act out different roles (Ray, 2011b). Real-life toys may include puppets, a family of dolls or animals, and a doll house with furniture. These toys allow expression of the child's feelings as the child can act out various family episodes, including conflicts, crises and problems with siblings. Cars, trucks, planes and cash registers may be especially useful for anxious, shy, or resistant children as they allow play without revealing any feelings. When children feel ready they tend to choose toys which allow the expression of feelings in more open ways. In CCPT no child is forced to talk about their feelings or express emotions. Feelings and emotions will be expressed spontaneously when the child feels safe and accepted by the teacher (Landreth, 2011).

Aggressive toys. Young children have limited ability to express their intense emotions verbally. This is where toys like soldiers, spiders, snakes and alligators may be useful as they allow children to express negative emotions such as anger, hostility, and frustration in a symbolic way. Play dough and clay can be both expressive and aggressive as children can smash, pinch and hit these art materials to express anger and frustration. A supportive environment in which children are

given an opportunity to express their negative feelings enables children to move on from these feelings to more positive and self-enhancing emotions (Landreth, 2011).

Strategy 2: Be reactive to children.

Just as the preschool environment is created as an inviting place for children, the teacher who delivers play therapy strategies should also be inviting and convey a genuine interest in what the child is doing and feeling (Landreth, 2011; Ray, 2011b).

Follow the child's lead. The teacher needs to create an atmosphere where the child is in the lead. The teacher follows the child's ideas, actions, feelings and decisions. The teacher begins the play session by gently joining in the child's play, not trying to change it. During each session the teacher should be in a position so that they can see the child but not attempt to enter the child's physical space or activity without the child's invitation. The teacher maintains an open posture towards the child, by leaning slightly forward, with their arms and legs positioned towards the child to communicate a sense of openness, interest and involvement. The teacher is relaxed, emotionally active and fully focused on the present moment while avoiding preoccupation with other thoughts and tasks (Landreth, 2011; Ray, 2011a,b).

Use a voice tone that matches the child's emotions. The teacher's tone should match the child's level of affect. Early childhood teachers often have a tendency to raise their tone of voice when talking to children or present themselves as overly animated (Ray, 2011b). While this seems appropriate for very young children, it "projects a basic attitude about children being incapable and has no place in the therapeutic relationship" (Landreth, 2011, p. 212). Similarly, an exciting tone of voice that goes beyond the emotions expressed by the child may be viewed as not following the child's lead but rather structuring and prescribing what the child should feel (Landreth, 2011). When the teacher matches the tone of voice to the tone of the child it communicates a genuine interest and acceptance of the child's emotions (Ray, 2011b).

Be real in your emotions. The teacher's tone of voice should also reflect their own words and emotions. This not only communicates genuineness to the child but helps them to experience the teacher more fully as a person. For instance, when a child accidentally hits the teacher with a toy, and the teacher, who may experience a feeling of anger or rejection, responds in a flat tone of voice, "Accidents happen in here", the child may see the teacher as not genuine which may further lead to a lack of trust in the relationship. In this case, a more emotional response, such as 'This really hurts, but sometimes accidents happen in preschool' would be more appropriate (Ray, 2011b).

Strategy 3: Follow the two general principles when responding to the child.

CCPT offers eight categories of specific verbal strategies (responses) which will be described further. There are two general principles which teachers should follow when they deliver these responses in order to reach a child effectively (Ray, 2011a,b).

Use short sentences. Children's limited language ability means that lengthy responses may lead to a quick loss of the child's interest. They also may be confusing for the child and even signal a lack of understanding on the part of the teacher (Ray, 2011a,b).

Match your speaking rate to the child's emotional level. When working with a quiet and reserved child, the teacher needs to slow their responses. If the child is highly energetic and talkative, the teacher may choose to reflect the child's level of energy by increasing number of responses. In initial play therapy sessions, the teacher may use a quicker rate of responding since the teacher's silence can make the child feel uncomfortable with the teacher in this new situation. Because it is a new way of responding to a child, teachers may feel uncomfortable when they first try to match the child's emotional level. However, with every new session, teachers will become more and more skilful in matching the child's level of emotions (Landreth, 2011; Ray, 2011a,b).

The following therapeutic responses communicate to children the teacher's involvement in their play, as well as convey acceptance, respect, and understanding. When teachers use these responses, it helps them to build a positive and therapeutic teacher-child relationship, which is necessary for marked growth/change in the child.

Strategy 4: Use the following verbal strategies when responding to the child.

Describe the child's actions. When the teacher describes what the child is doing, it conveys the teacher's acceptance of the child and communicates the teacher's interest in whatever the child is doing (Ray, 2011b). At the same time the child's "feelings of security and warmth are promoted" as the child hears the teacher describing their actions and activities (Landreth, 2011, p. 212).

Examples of responses:

Child's actions:

Teacher may respond:

Picks up a doll

'You're picking that up.'

Rolls the ball

'You're rolling that all the way over there.'

Makes collage

'You are putting lots of glue on that.'

Puts play dough into a container

'You are putting this right there.'

Restate what the child says. Teacher restates or paraphrases what the child is saying. In this way of responding, the teacher validates the child's perception of their experience and promotes self-understanding.

Examples of responses:

Child's actions:

Teacher may respond:

Describes the movie she watched.

'You saw Harry Potter and there was a lot of action.'

Talks about visiting her friends.

'You went to see Ella and Jonty.'

Talks about seeing a doctor.

'You went to a doctor and he gave you some medicines.'

Describe the child's emotions. The teacher describes emotions exhibited by the child during play. In other words, the teacher verbally reflects the child's emotions in the times when the child is happy, confident, curious, excited, sad, lonely or angry. This type of response helps children to recognise their emotions and learn vocabulary to express these emotions so they have the ability to recognise and cope with their negative feelings (Ray, 2011a,b).

Examples of responses:

Child's actions:

Teacher may respond:

Shows you a picture.

"You're really proud of your picture"
(Ray, 2011b, p. 21)

Asks you to read more books.

'You really wish that we could read more books.'

Says: 'I want to go home.'

'You are sad about being here and you want to be at home.'

Promote decision-making and return responsibility. One of the goals of CCPT is to help children develop an image of themselves as capable and self-reliant individuals. Therefore, the

teacher should avoid doing for the child what they can do for themselves. Instead, the teacher should respond in ways that facilitate decision making and return responsibility to the child (if it is clear that the child is capable of doing the action themselves) (Landreth, 2011; Ray, 2011a,b).

Examples of responses:

Child's actions:	Teacher may respond:
Asks you, 'What should I do in here?'	'In here, you can decide what to do.'
Asks you, 'Can you help?'	'That looks like something you can do.'
Asks you when drawing a picture, 'What colour are caterpillars?'	'You can decide what colour you want the caterpillar to be.'
Asks you, 'I want to go outside, what do other kids do outside?'	'Oh, so you'd like to go outside. In here, you can decide what you want to do outside.'
Wants to go inside and asks you, 'Please, take my jacket off.'	'You have decided to play inside and want your jacket off. You can take your jacket off if you want it off.'
	(Landreth, 2011; Ray, 2011b)

This way of responding helps the child develop a positive view of "self" and conveys confidence in the child's ability to find a solution on their own.

Promote creativity and spontaneity. Another goal of CCPT is to promote the child's sense of creativity and help the child experience freedom of expression. The teacher's acceptance and encouragement of the child's creative ideas conveys to the child that they are special and unique.

Children with behaviour problems often exhibit rigid ways of acting and thinking. Being creative helps them to develop their repertoire of actions and flexibility in thought.

Examples of responses:

Child's actions:	Teacher may respond:
Asks, 'What colour should the butterfly be?'	'Your butterfly can be whatever colour you want it to be.'
Takes a piece of clay and asks, 'What do you make with this?'	'In here, you can decide what you want to make with this.'
Shows you a picture and asks, 'What do you think this is?'	'You can tell me.'
Shows you a piece of play dough and asks, 'Guess what I'm going to do with it.'	'Hmm, you have something in mind.'

(Landreth, 2011; Ray, 2011b)

Encourage and build the child's self-confidence. Teachers who practice CCPT should constantly aim at promoting the child's sense of personal worth. Encouragement and esteem-building responses can be delivered strategically to achieve this goal. Such responses focus on the child's efforts in accomplishing the task and place value on the process of trying to achieve (Ray, 2011b). In other words, encouragement and esteem-building recognise the child's contribution, perseverance, and determination (Dweck, 2007).

Initially, early childhood teachers may have difficulties with distinguishing between praise and encouragement. Praise places an expectation on the child to perform for the teacher, and creates external motivation, while encouragement and esteem-building responses facilitate development of self-assessment and an inner sense of what is right (Ray, 2011b).

Examples of responses:

Child's actions:	Teacher may respond:
Shows you a collage, she has created.	'You are so proud of your collage' or 'You created this just the way you wanted.'
Just created a complicated block structure.	'It was hard to make, but you did it.'
Shows you a picture and asks, 'Do you like it?'	"What is important is how you feel about it" (Landreth, 2011, p. 282).
Puts a puzzle together.	'Your worked really hard on that' or 'You figured it out.'
Tells you about butterflies.	'You know a lot about butterflies.'
Working on a complex puzzle.	'You are working hard on this, you will figure it out.'

Facilitate relationship. Relationship building responses facilitate the development of the relationship between the teacher and the child. This category of responses helps the child to experience a positive relationship and develop strategies for effective communication. As the relationship between the teacher and the child models real life relationships, the child's attempts to

address the relationship should be responded to. Relational responses consist of “a reference to the child and reference to the self” as teacher (Ray, 2011b, p. 21).

Examples of responses:

Child's actions:

Teacher may respond:

Cleans up the play dough table and says,
'Look, now you don't have to tidy up.'

“You wanted to do something to help
me” (Ray, 2011b, p. 21).

'You know, my friend Ella...' (tells you
how Ella found new friends at school).

'You wanted me to know how she found
new friends'.

'I hate you. I'm going to eat you up.'
(This response comes after a teacher set a
limit with a child, who wanted to shoot
her with the gun).

“You're really mad at me that I'm not for
shooting. You want to punish me” (Ray,
2011b, p. 21).

Set limits. When teachers establish limits, they provide security and consistency for the child. In CCPT minimal limits are encouraged since the goal of the therapy is to help the child develop self-control and self-responsibility. Limits should be established when the child exhibits harmful or dangerous behaviour, damages toys or play materials, or if their behaviour impedes teacher acceptance (Landreth, 2011; Ray, 2011b).

In CCPT the ACT model for limit setting is utilised. It involves (a) acknowledgement of the child's feeling; (b) communication of the limit; and (c) targeting an alternative behaviour. For instance, when a child wants to paint on the walls, the teacher may recognise and validate the child's feelings by saying, 'You're so excited about the paint.' Secondly, the teacher establishes a firm and short

limit, 'But walls are not for painting on.' Then, the teacher gives the child an alternative to the action, by saying 'the paper is for painting on' (Landreth, 2011; Ray, 2011b)

Landreth (2011) believes that when the child is given an alternative, they have a choice of either acting on the original impulse or being engaged in the alternative behaviour. By providing this choice for the child, the teacher facilitates decision making and allows the child to take responsibility for making their own decisions. If the child decides to paint on the paper, it will be the child's decision (in this case the child learns self-control), not the teacher's.

Session Outlines

Session 1: Early Childhood Teachers Using Play Therapy, the Concept of CCPT, Links to *Te Whāriki*, Strategy 1.

I. Welcome

Greeting teachers.
Leader's introduction.

II. Training objectives

Overview of the training, objectives, content and training format.
Passing out handouts.
Video 1: play therapy introduction.

III. Content

Announcing the topics to be covered.
Brainstorming the benefits of, and barriers to, child centred play with teachers.
Video 2: early childhood teachers using CCPT strategies.
Discussing the concept of CCPT, links to *Te Whāriki* and explaining how teachers can use CCPT strategies in their centre.
Brainstorm: preparing for the play session.
Introducing strategy1: preparing for the play session.
Role play: selecting appropriate toys for the session.

IV. Closing the session

Summing up what has been learnt in the session.

Thanking teachers for their participation.

Session 2: Strategies 2-4.

I. Welcome

Greeting teachers.

II. Content

Announcing the topics to be covered.

Brainstorming ideas for non-verbal responses.

Discussing strategy 2.

Video 3: body language of an early childhood teacher.

Role play: one teacher is a child, another demonstrates non-verbal responses.

Discussion on how non-verbal responses can make the child feel.

Introducing strategy 3.

Video 4: describing behaviour.

Discussion on the effects of this strategy on the child.

Talking about describing the child's feelings.

Video 5: describing the child's emotions.

Brainstorm: what might be the child's feelings in video 5.

Discussing decision making and returning responsibility responses.

Role play: one teacher is a child, another demonstrates returning responsibility responses.

Encouragement and esteem-building responses.

Video 6: limit setting.

The act model for limit setting.

Role play: one teacher is a child, another demonstrates the act model for limit setting.

Discussion on how this model can be implemented in an early childhood setting.

III. Closing the session

Summing up what has been learnt in the sessions.

Talking about the third day of training (coaching teachers at the preschool).

Reminder that the researcher is available to answer questions and to provide continuous support during the delivery of the strategies to children.

Thanking teachers for their participation.

Chapter 5 Results

This chapter describes how the teachers delivered the CCPT intervention and next describes the impact of the teachers' efforts on the children's behaviour. The results are, therefore, organised to present qualitative results for the teachers first, which are followed by the results for the children.

Results for Teachers

Teachers' interviews were taped and transcribed and, as is appropriate in qualitative research analysis, the excerpts were listened to, and read a number of times to expose emerging themes across interviews. The results of this process are described below. To indicate the source of data, verbal excerpts which include transcribed recordings and teachers' comments noted by the researcher have been italicised. Teachers' non-verbal excerpts such as the comments written as reflections in their satisfaction questionnaires have been presented as plain, unitalicised text. A series of three dots has been used to indicate that the researcher has edited the excerpts by taking out words or phrases. Phrases taken out and replaced by dots were either repetitions, or phrases where speakers were referring to another topic. Square brackets containing the word 'pause' are used to indicate pauses.

Delivery of the CCPT training. Three main themes of participants' perceptions about the training emerged as teachers were asked about the delivery of the CCPT training. First, teachers appeared to have enjoyed attending the training outside their work environment. Second, they seemed to have found role-plays helpful for their understanding of CCPT concepts. Third, the realisation that all teachers make mistakes was cited as being an important factor for finding the CCPT training helpful.

Being trained outside work environment. Teachers stated that the experience of being trained outside of their work environment provided them with the opportunity to emotionally disengage

from their teaching duties and, thus, to better focus on the training curriculum. For example, Cathie said:

...We're very busy on the floor, just doing things outside [pause]. [Being] out of the environment too, like going to the University, I felt that is a good idea because you're out of the environment ... It is always rolling over in my head, rolling over in my head. But just being [in a different environment] was a bit more relaxing for me.

Participating in role-plays. Role-plays were an important part of the CCPT training. They were utilised for illustrating CCPT strategies and for addressing issues brought up by teachers. Teachers perceived role-plays as extremely beneficial for their understanding of the CCPT model.

For instance, Lee reflected on the important role-play episode that took place during the training. In this episode, the researcher used a rope as the analogy to illustrate the concept of a teacher centred curriculum rather than a child centred one. One teacher was 'the child' and another played 'the teacher'. The rope connected 'the teacher' and 'child'. 'The teacher' was asked to pull the rope back to herself each time 'the child' was talking or initiating an activity without giving 'the child' a chance to lead. Lee wrote:

Through role modelling with my colleague I discovered some things about my own practice I quickly wanted to rectify. One exercise where she pretended to be a child and I her teacher where we pulled on a rope and we both tried to keep the conversation centred on ourselves was a real eye opener.

She later said:

That [role-play] I found really good because it was the real eye opener, because I suddenly kind of thought back on practices and what it wasn't that extreme I kind

of went “Oh, God, I do that!” And it was, it was horrifying but in a good way because at least I saw that I did that rather than carrying on doing the “Oh, yeah, but that’s okay because I’m doing that...You know, and it was really quite frightening [laughs]. That was the bit I would say I enjoyed the most because that was such an extreme example. But I think it needed to be that extreme to make it real and it opened my eyes to that.

Being reassured that mistakes are okay. When asked what other factors had been helpful during the CCPT training, teachers indicated that they had been reassured by the realisation that teachers and therapists do make mistakes and that is a normal part of any learning process. In particular, Lee referred to a video vignette used during the training in which a trained therapist experienced a moment of hesitation when responding to verbal aggression from a child:

... it [the video] was very empowering because it means I am not a trained therapist so it doesn’t matter, you know, making mistakes is okay. I think it’s also good because when children see “okay they make mistakes, I make mistakes, that’s just kind of like: we all learn from those. And trained professionals can make mistakes, it’s kind of like...so, it’s good.

This excerpt highlights this teacher’s deepened understanding that teachers, just like children, learn and make mistakes. The teacher also discovered a great educational value of teachers making mistakes, as she considered that children observe their teachers continuing to learn and problem-solve to arrive at more effective ways of doing things. This was regarded, by this teacher, as a strength associated with the CCPT.

Implementation of the CCPT strategies in practice. Two main themes of participants’ perceptions about the implementation of CCPT strategies in practice emerged when teachers were asked about this. Both focused on difficulties the teachers encountered when they went to implement the new

strategies. First, the teachers highlighted the need for support by other teachers. Second, they talked about being creative about finding time to implement strategies.

Need for support by other teachers. Teachers remarked that although they had supported each other during the implementation stage, they would have preferred to attend the training with their colleagues to enable consistency within the centre. Cathie stated:

I think all the staff learning this together would have been a great idea. I know that it was just two teachers but I think ... Just to keep growing with that and that consistent [pause]. Like as I'm working with one child it's nice that the other teachers can work alongside me too.

Being creative about finding time to implement strategies. Teachers found that they often had to be creative in finding appropriate times to deliver the strategies. Lee, for example, reflected on how she had to be very resourceful in order to find times to implement the CCPT strategies with Tui:

I found implementing the strategies in general easy, but not so easy at first with my study child. It was not that he was not willing to join in, but first his hours dropped so he became part time, not full time. He has subsequently gone back to being full time again. And secondly, he was never dropped off when he was meant to be – he always arrived over an hour or more late. When he played inside I was the outside teacher – or outside while I was inside, which compounded the issue for a while. Unfortunately, two weeks into this process, his father died...he was away for a number of days for the tangi. So finding the time to implement these strategies with him proved to be difficult in the first three weeks or so.

Teachers’ overall perceptions of the impact of the CCPT training. When teachers were asked what they thought about the CCPT training they reported that it had been a valuable and beneficial experience. In their written feedback, the teachers described it as “excellent”, “really good”, and “a real eye opener”. They suggested a variety of reasons for their positive perception of the training.

It has given me strategies that I can continue with. I am more open and can see when children need help (Cathie).

This has helped remind me that we as educators are here for the children. Things work better when child directed rather than teacher lead. It’s more fun and can take us in unexpected directions (Lee).

Four main themes emerged in relation to teachers’ perceived benefits of the CCPT training. As a result of the training, teachers appeared to have found positive changes in: children’s behaviour; their own ability to accept and understand children; the level of confidence and self-efficacy in the teaching role; and their personal and professional development. A summary of these themes is presented in the Table 6 below.

Table 6

Themes Arising From the Teachers’ Data

Main themes	Sub-themes
Positive behavioural changes in children	<p>The impact of the training on the behaviour of target children</p> <p>The impact of the training on the behaviour of the other children</p>

Main themes	Sub-themes
An increased ability to accept and understand children	<p>Developing warm and trusting relationships with target children</p> <p>Developing warm and trusting relationships with the other children</p> <p>Understanding underlying causes for behaviour problems</p>
An increased level of confidence and self-efficacy in the teaching role	<p>Seeing themselves as agents of change</p> <p>Being equipped with new effective strategies</p> <p>An increased feeling of joy when being with children</p>
Unanticipated personal/professional development	<p>Taking a risk when integrating new strategies</p> <p>Using new skills outside the early childhood centre</p>

Positive behavioural changes in children.

The impact of the CCPT training on the behaviour of target children. The teachers commented that their participation in the training had brought improvements in the behaviour of target children.

As Cathie stated:

It's seeing the little improvements of the child and thinking "Yeah", and actually taking, like, yes it was joy, it was joy from that. It was sometimes, you know, you were holding back the tears, I was just seeing that little bit of an improvement, and a couple of things that were done and you think: "Oh my God, he did that!"

Cathie commented on Peter's increased ability to empathise with the other children and express his emotions and needs verbally. This comment followed Cathie's description of this episode:

The other day a child took another child's lunchbox while they were outside having a picnic. Peter immediately got up and went over to where the child was putting the lunchbox; he picked it up and looked at the child, and he said, "that is not right." He took the lunchbox back to its owner and gave it to her. I felt very proud of what Peter had done and I went up to him and told him how proud of him I was.

The teacher later reflected:

Peter is working on his social competency skills and this event showed me just how far he has come in the short time I have been using play therapy. It is giving him the skills to develop relationships with the other children and allowing him to develop empathy for others.

Lee reflected that she noticed an improvement in Tui's ability to engage in conversations with her and other children. She also emphasised his improved ability to talk about his feelings and wishes rather than act in destructive ways.

The days where he invites me into his conversations – simply him and I on our own, or with his peers, have increased.

She later stated:

Play therapy strategies are working great with Tui as he is now more verbal and able to express his emotions and needs verbally and in an appropriate way.

The impact of the CCPT training on the behaviour of the other children. Teachers highlighted that their participation in the training had brought about improvements not only in the behaviour of target children, but also in the behaviour of other children in their centre.

Seeing quick positive changes in the behaviour of target children appeared to have played an important role in the teachers' willingness to implement play therapy strategies with the other children. As Cathie stated:

It is definitely working with Peter and I am now using it with the other children.

The other day when children were climbing on the monkey bars I started to describe what they were doing and they just loved that. One boy said to me:

"Look" and showed what he did as if he was saying "describe what I can do!"

They [all children] listen more, they do not push boundaries that much anymore!

This view was supported by the colleague - Lee, as she commented:

[I noticed results] almost immediately. It was funny like with both Tui and Peter it was kind of like definitely noticing with those two. But also with the other children around, you know. It's sort of like all of them, all the children when they get the "You're doing this, you're doing that", "You're using this, you're using that. Rather than putting the labels. All [children] opened up. And, well, either carried on, doing what they were doing or they started verbalising what they were doing, you know. And so it's kind of like depending on where the child is at. But it's also with the very young and the children almost ready for school. All of them showed massive improvements. That blew me away!

This verbal excerpt shows how the teacher perceived play therapy strategies as helpful for children of different ages and levels of development. In particular, the teacher referred to the strategy of

verbally describing the child's actions. She briefly mentioned her personal learning about the strategy, that it may evoke different reactions from children depending on their developmental stage.

The same teacher also said that the CCPT training had resulted in "a huge difference" in the behaviour of children who had difficulties separating from their parents. There is now an awareness that describing and verbalising children's feelings promoted the children's ability to recognise and understand their own emotions and helped them cope with negative feelings more easily:

I noticed like especially with children who are settling, they settle a lot quicker, when [pause] It's like: "You're upset. You want your mum. You don't want to be here". You know, it's kind of like, when the child feels that their feelings are being validated, whatever the situation is, whether...especially with this transitioning period, they settle a lot quicker.

And later she said:

I remember, it was one boy, he was kind of like on the first day I was 20 minutes doing this and repeating, repeating, repeating. So, it was about 20 minutes. And then, the next day, it was five. That was a huge difference! And it was just that whole kind of the describing exactly what they were: "You are sad", "You are crying", "You are upset", "You want your mum" "You don't want to be here". Rather than: "Oh, look, it's gonna be okay. You'll be fine. Suck it up", you know. And then the child might stop crying but they don't feel better.

An increased ability to accept and understand children.

Developing warm and trusting relationships with target children. Teachers' participation in the CCPT training appeared to have played an important role in developing warm and trusting relationships with their target children. Cathie reflected on an episode with Peter when she felt

proud of him being able to stand up for another child. She shared these feelings with him and this appeared to help the target child to experience the teacher as a sincere and honest person which, in turn, seemed to build more trust in the relationship:

Recently there was a situation with two children; one of them went up to the other and very sharply said, 'Give me my hat back'. Before I had a chance to say something to the child, Peter, who had been listening came up to the child and said in a very nice voice, 'That is not nice'. I went up to Peter and told him that I was very proud of him, he was open to getting a hug and I actually felt tearful pride as I told him how proud of him I was. I was more than comfortable in sharing this honesty with Peter and believe that by sharing my feelings with him we continue to develop a trusting relationship with each other. I feel that this is evidence of play therapy working well for Peter; he continues to modify his own behaviour and this has extended to him seeing other children when they act inappropriately.

Similarly, Lee reflected on how her relationship with Tui evolved during the process of implementing play therapy strategies at the centre. An increase in feelings of warmth and acceptance as well as the teacher's willingness to follow the child's lead and ideas appeared to have brought more opportunities for playful and enjoyable interactions:

The next morning Tui seeked [sic] me out. He opened the conversation and we chatted away for several minutes before he gave me one of the greatest compliments I have ever been paid. We were being silly – he started saying 'Hello Lee, cheeky monkey'. With me responding 'Hello Tui, cheeky monkey' and both of us falling about laughing. When all of a sudden he looked at me in the eyes, and

said ‘You have Ben 10 eyes’. I know how much he loves Ben 10, so I knew this had great significance to him.

Here, the teacher described an incident which was very different from her interactions with the child before using play therapy strategies. This excerpt illustrated how the child had developed a perception of the teacher as a fun, accepting and safe person; safe enough for him to be playful, to be “silly” and to be himself. The atmosphere of warmth and acceptance that had been created as a result of play therapy strategies led the child to pay a special compliment to his teacher in which he associates her with his favourite character.

Developing warm and trusting relationships with the other children. In addition to the positive shift in the relationships with their target children, teachers indicated that the CCPT training had helped them to establish more positive relationships with other children in their centre. As Lee reflected:

The relationships I have with all the children have become deeper than they were. Since implementing play therapy into my practice and becoming more focused on the children by following their lead, I have enjoyed work more.

Understanding underlying causes for behaviour problems. One of the factors which appeared to have contributed to the teachers’ increased ability to accept and understand children was the teachers’ improved capacity to understand the underlying causes for behaviour problems in children. For example, Lee recalled how understanding Tui’s disrupted family circumstances helped her realise that trying to apply strategies would be difficult:

I can understand now how all these changes in his life affect his behaviour
[pause] *he is not being naughty, he shows us that he needs help.*

Similarly, Cathie felt that identifying causes for behaviour problems in children was essential:

I now really think hard about why they behave this way. I think about what's going on at home, their extended family.

An increased level of confidence and self-efficacy in the teaching role.

Seeing themselves as agents of change. One of the dominant themes to emerge was that the CCPT training appeared to have helped teachers to see themselves as capable of creating a change in children's behaviour and life. As Lee reflected:

...I discovered that as little as two 15 minute sessions a week, focused on a child can make a huge difference in their life. Regardless of the child's circumstances, or behavioural issues, having at least one adult who focuses exclusively on them for two small periods a week can lead to massive positive changes for that one child. I wanted to see how I could be that change for all the children in my life – not just at work.

This view was supported by Cathie who realised that building strong relationships with children might not be an easy task. However, she saw her responsibility as a teacher to build positive relationships with her students in order to help them learn and develop strong social skills. Later in her reflection, she identified to herself some directions for further work in this area:

As a teacher I realise that not all children will build a relationship with me in the same way. My experience with Peter has shown me that I must always be looking for ways to engage children so that they can learn and develop good social competency skills. There are a couple of other children at kindergarten that I would like to begin using the play therapy strategies with in order to build a closer relationship with them.

Being equipped with new effective strategies. Teachers also commented that their participation in the CCPT training had helped them to acquire new ways of supporting children's learning. In particular, Cathie reflected about the usefulness of play therapy strategies in developing children's communication and social skills and promoting their emotional understanding and self-regulation.

Over time I have stuck with it and continued to practise using the play therapy model...I can see this method enhances children's language, improves their social competency skills, and ensures that the child's flow of play is not interrupted. Acknowledging the children's emotions allows them to self regulate their behaviour and to become familiar with their own feelings. I will continue to build my skills as I use this technique in my practice and believe using it benefits the children's overall learning.

Lee reflected on how the CCPT training had played an important role in facilitating change in her teaching. The teacher had come to recognize that children are capable of 'reading' adults' emotions and seeing when adults "are not really present with them". This realization had affected her presence and genuineness with children and had, as a result, brought more satisfaction in her teaching role.

Before doing this [training], I had found myself stuck in my teaching practices. I couldn't find ways to make things work. To be perfectly honest, nothing was really working. I was frustrated, and so was everyone around me – teachers and children alike. Realising that I needed to change where I was coming from has helped a great deal. Play therapy will not work when I come from a place of frustration, boredom, or indifference. Children can read other people far better than adults can, and they know when adults don't mean what they say, or when

they are not really present with them...All the children in the centre found this more satisfying. And to be honest, so did I.

An increased feeling of joy when being with children. Greater confidence and satisfaction in their own teaching as a result of using CCPT strategies appeared to have led teachers to be able to enjoy working with children. As summarised by the comment made by Lee:

You know, and it's magic being at work... the children are enjoying being around me which makes me enjoy being around the children which [pause]. So, it's kind of like, it's a snow ball effect but in a positive way.

Unanticipated personal/professional development. I expected participants to appreciate the effect of their use of CCPT on their target children, however, I found that the value of interviewing teachers was the ability of unanticipated personal/professional development in teachers to emerge.

Taking a risk when integrating new strategies. On the third day of training Cathie expressed uncertainty, stating that the strategy of describing children's actions might work in theory, but could never be more effective than the strategy of questioning. When exploring the reasons for such belief, I found that when the teacher had been in training for her Early Childhood Diploma she had been taught to extend children's learning by asking open-ended questions. When at the end of the study, the teacher was asked about what she had found challenging during the training, she referred to this dilemma by saying:

Well, for me, the unsure bit was: okay describing what they were doing instead of asking open-ended questions all the time. Like when we were training for the diploma it was: ask open-ended questions.

Cathie also reflected:

Initially I found using these strategies quite challenging as I was used to asking questions. This technique requires me to think quite strategically about what I can say to children when I am involved in their play.

To address the teacher's scepticism regarding the strategy, I validated the teacher's position and agreed with Cathie that she would use the strategy with Peter. However, at the end of the study she would decide whether to continue using the strategy in her teaching. This approach appeared to have helped Cathie to deepen her understanding of the strategy and to see the value of it in her teaching. This is what Cathie noticed when she just started to apply the strategy with Peter:

Over the past few weeks I have been working alongside Peter using the play therapy model. He has been describing his play to me and we have built a reciprocal and responsive relationship as I have described his play to him and then he will describe it back to me. By doing this we have been able to build a relationship which reflects trust and respect.

At the end of the study, Cathie said:

I was a bit sceptical and I gave it a go and I found it very positive.

This willingness of the teacher to trust the CCPT strategies appeared to have played an important role in facilitating change in Cathie's belief about the strategy and created a significant shift in her teaching. This change is illustrated in her reflection:

In the past my teaching practice has relied heavily on asking the children open ended questions, such as "What are you making?" In this instance the play therapy strategy would be to say, "I can see that you are filling up your red cup

with sand.” The advantages of using these strategies are that the children are empowered to describe what they are doing in their own way and in turn this builds their confidence and enhances their learning.

Using new skills outside the early childhood centre. Another unanticipated factor was that the training appeared to have positively impacted not only teachers’ professional practice but also other areas of their life. For example, Lee stated that she found her participation in the training beneficial both from a personal and a professional perspective:

... it’s not only just for when I am at work when I have my teacher hat on. But, it’s when I have my Lee hat on, was kind of like wherever I am. And that was really amazing.

With regard to personal benefits, the teacher highlighted her improved ability to support her family members with their children. In particular, she described a difficult family episode when her knowledge of CCPT strategies had helped her to effectively support her sister struggling with putting her young child to bed:

Even [sister’s name] was saying, “He never goes to bed and stays in bed” and he did that time because I was... focussing directly on him.

The same teacher later added:

I know especially with family I don’t always be quite as calm as I am at work, you know. Because, it’s [pause] your family, you don’t have to be professional; you don’t have to have your teacher hat on with family. But trying it [helping sister] had made such a huge difference...

Comments on the Teacher Satisfaction Questionnaires. The clear consensus from both teachers who were asked to what extent the training was helpful was that it had been *very helpful*. The section asking about the participants' overall feelings about the training was rated as *positive* by Cathie and *very positive* by Lee who also commented: "I am positive that I will continue this in my practice every day". Both teachers indicated that they would *strongly recommend* the training to others. Cathie wrote: "Over the last 18 months my centre has been looking at social competency and play therapy has consolidated the improvements we have made". The training also appeared to have helped teachers to gain more confidence in their ability to manage future problem behaviour at their centre using the CCPT as both teachers indicated that they were *very confident* in this area.

When asked what they found most helpful about the training, Cathie commented: "Reminding myself that children's play is so much fun! It is unpredictable and leads to new learning. The fact that children learn to self-regulate through play is an added bonus." Lee wrote that the most helpful about the training was that she is now "...more open with all children and understanding what the children are going through" and how to build "strong lasting relationships" with them.

The questionnaire asked teachers how the training could have been improved to help them more. Neither teacher had found that the training should have been improved in any way. This feeling is well summarized by Cathie, who commented: "The training was excellent, I wanted to see results and I got the results and I don't see how it can be even more helpful!" Lee indicated, however, that it would be great if all the staff could participate in the training.

Overall, Cathie seemed to have enjoyed the training. Although she felt quite reserved about using the strategies in the beginning, she took a risk of implementing them and it paid off in terms of improvements in Peters' behaviour and achieving a better relationship with him.

Lee too, appeared to have enjoyed her participation in the CCPT training. She described how the use of the CCPT strategies helped her regain her teaching confidence, build warmer relationships

with Tui and other children within the centre and brought noticeable improvements in the children's behaviour.

Results for Children

Positive play.

Peter. For Peter, the percentage of positive play intervals increased immediately and noticeably upon introduction of the CCPT intervention (Figure 1). During the baseline condition, the percentage of intervals during which Peter displayed positive play behaviour in the centre was 61% (range, 51%-61%). During the CCPT intervention phase, the percentage of positive play intervals increased to 98% (range, 60%-98%). The PND score was 100% (Figure 2), indicating that the intervention was effective (Parker et. al., 2011).

Tui. For Tui, the percentage of positive play intervals increased substantially with the CCPT intervention (Figure 1). During the baseline condition, the percentage of intervals during which Tui showed positive play behaviour was 72% (range, 50%-72%). During the CCPT intervention phase, the percentage of positive play intervals increased to 90% (range, 48%-90%). The PND score was 100% (Figure 2), showing a large effect (Parker et. al., 2011).

Problem behaviours.

Peter. For Peter, the percentage of problem intervals decreased immediately and substantially upon introduction of the CCPT intervention (Figure 1). At baseline, the percentage of intervals during which Peter was engaged in problem behaviour in the centre was 48% (range, 38%-48%). During the CCPT intervention phase, the percentage of problem intervals decreased to 1.7% (range, 1.7%-35%). The large magnitude of this decrease was evidenced by the PND score of 100% (Figure 3).

Tui. For Tui, the percentage of problem intervals decreased immediately after introduction of the CCPT intervention (see Figure 1). At baseline, the percentage of intervals during which Tui displayed problem behaviour was 21% (range, 21%-37%). During the intervention, however, the percentage of problem intervals decreased to 8.3% (range, 8.3%-41%). The PND score of 100% (Figure 3) denotes a strong effect according to Parker et al. (2011) guidelines.

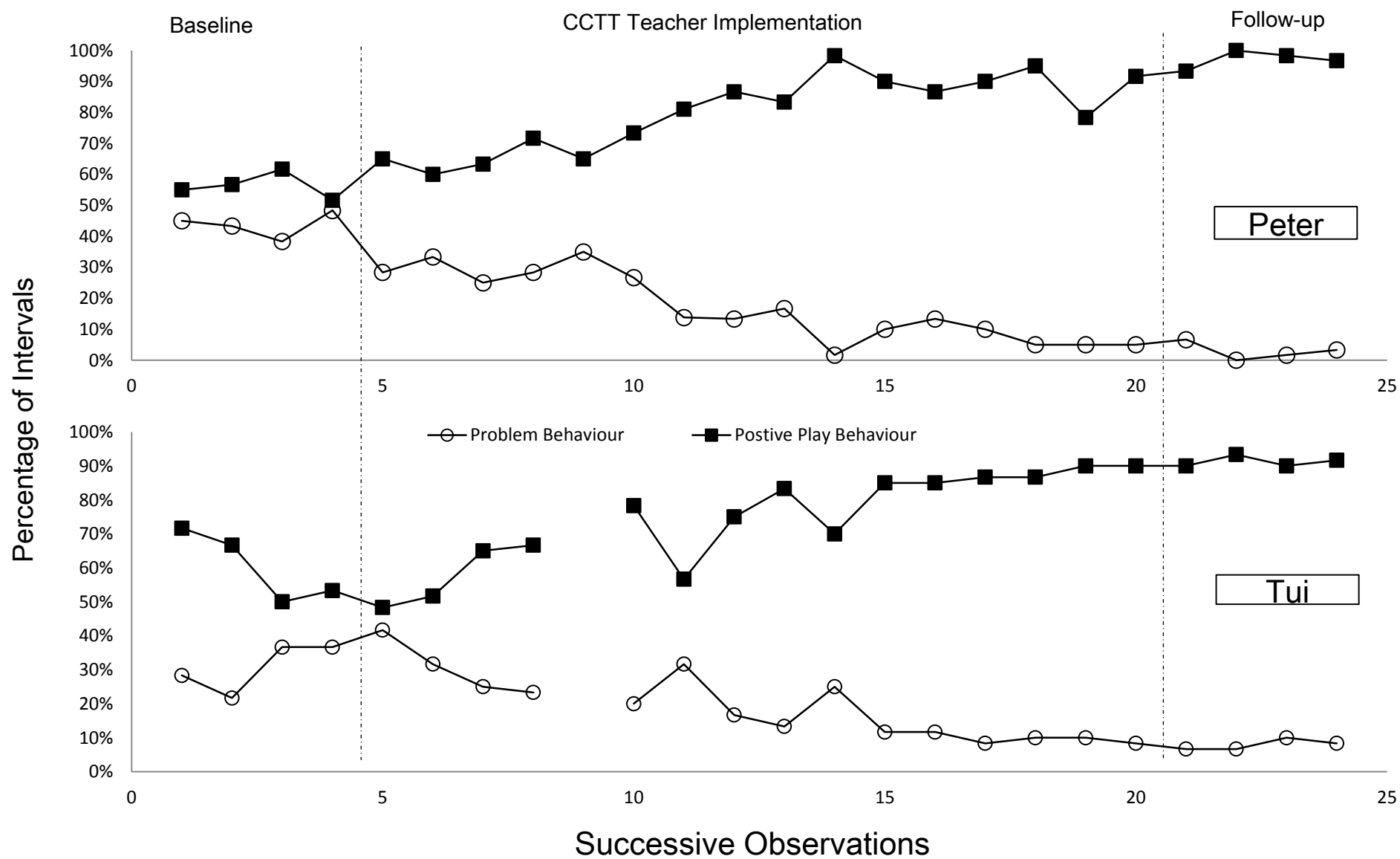


Figure1. Percent of intervals with observed positive play behaviour and problem behaviour for Peter and Tui.

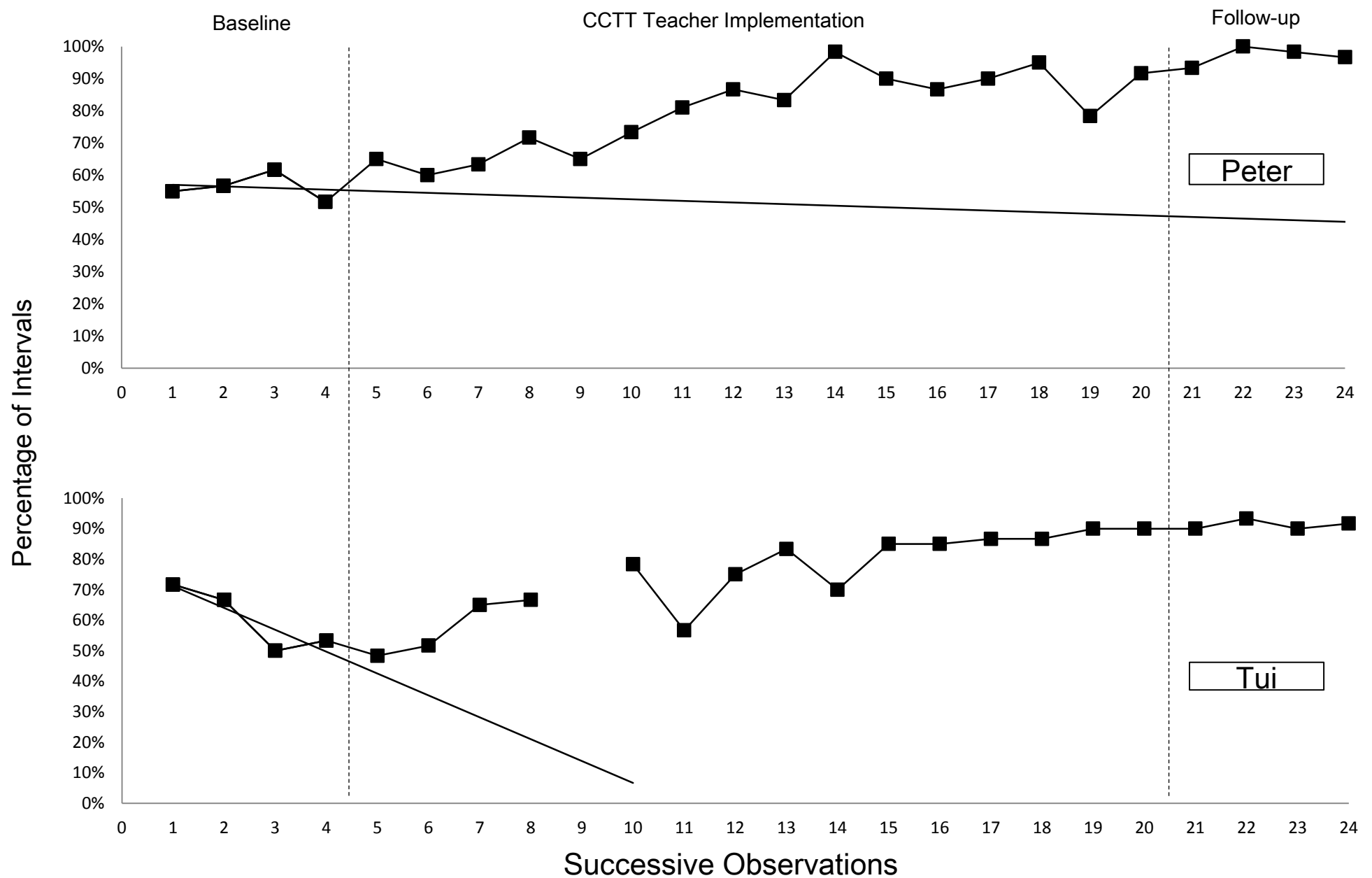


Figure 2. Percent of intervals with observed positive play behaviours for Peter and Tui. The line drawn during baseline is the Extended Celeration Line (ECL) used to estimate effect size (Parker et al., 2011).

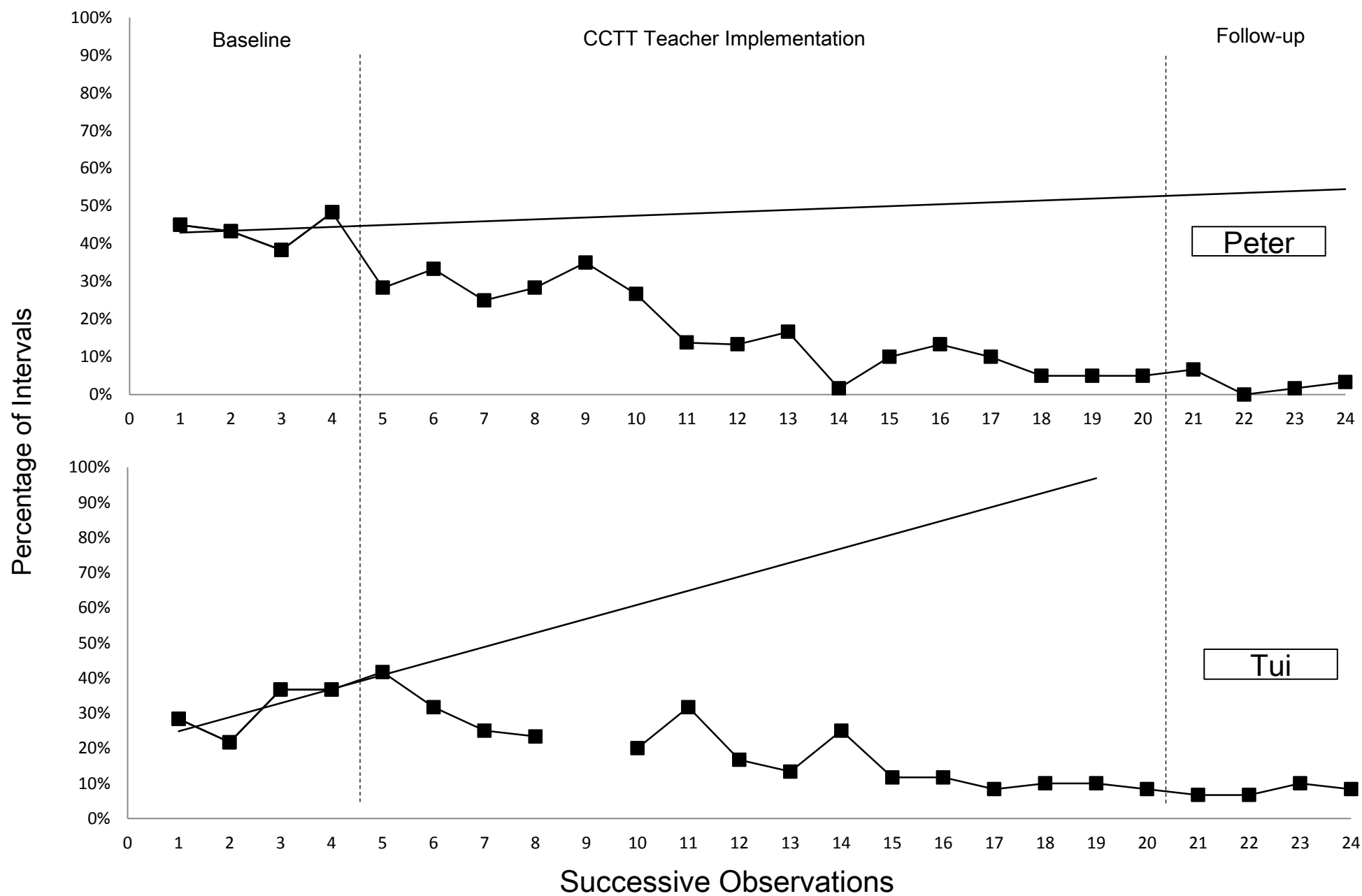


Figure 3. Percent of intervals with observed problem behaviour for Peter and Tui. The line drawn during baseline is the Extended Celeration

Line (ECL) used to estimate effect size (Parker et al., 2011).

Strength and Difficulties Questionnaire.

Peter. Baseline and follow-up scores on the SDQ (Goodman, 1997) for study children are shown in Table 7. The *Total Difficulties* score for Peter reduced from the *abnormal* at baseline into the *normal* range at follow-up. The *Hyperactivity* scores also improved from the *abnormal* into the *normal* range at follow-up.

The reported *Emotional Symptoms* scores for Peter remained within the *normal* range at baseline and follow-up. The *Conduct Problem* scores for Peter remained in the *abnormal* range at baseline and at follow-up. The *Hyperactivity* reported scores improved from the *abnormal* range at baseline to the *normal* range at follow-up. In particular, Peter's scores improved from 8 to 5. The *Peer Problems* and *Prosocial Behaviour* reported scores for Peter remained within the normal range at baseline and following the intervention.

Peter's *Difficulties Upset Child* scores improved from the *borderline* at baseline to the *normal* range. The *Interference with Peer Relationships* scores for Peter did not change as a result of the intervention. The *Interference with Learning* reported scores improved from the *borderline* at baseline to the *normal* range at follow-up. In addition, an individual effect size for Peter's changes in SDQ scores, calculated using the Added Value Score formula (Ford, Hutchings, Bywater, Goodman, & Goodman, 2009), was large (0.9).

Tui. The *Total Difficulties* gained score for Tui reduced from the *abnormal* at baseline into the *normal* range at follow-up. His scores in *emotional*, *conduct problems*,

hyperactivity, total difficulties, prosocial and child upset all were in the abnormal range at baseline and improved into the normal range at the follow-up.

The reported *Emotional Symptoms* scores for Tui decreased from the *abnormal* (7) at baseline to the *normal* range (0) at follow-up. The *Conduct Problem* reported scores improved from the *abnormal* (7) to within the *normal* range (0) following the intervention. The *Hyperactivity* scores also improved from the *abnormal* range at baseline to the *normal* range at follow-up. In particular, Tui's scores improved from 10 to 4. The *Peer Problems* scores remained within the normal range at baseline and following the intervention. The *Prosocial Behaviour* scores for Tui increased from the *abnormal* (3) at baseline to the *normal* range (8) at follow-up.

The *Difficulties Upset Child* scores for Tui improved below the level of *clinical* concern at follow-up. The *Interference with Peer Relationships* scores for Tui reduced from the *borderline at baseline* to the *normal* range at follow-up. The *Interference with Learning* reported scores improved from the *borderline* at baseline to the *normal* range at follow-up. An effect size for Tui's changes in SDQ scores was very large (3.1).

Table 7

Study Children Baseline and Follow-up Teacher Reports: Strengths and Difficulties Raw Scores

SDQ	Peter		Tui	
	Baseline	Follow-up	Baseline	Follow-up
Difficulties				
Emotional Symptoms	1	0	7*	0
Conduct Problems	6*	5*	7*	0
Hyperactivity	8*	5	10*	4
Peer Problems	1	1	1	0
Total Difficulties	16*	11	25*	4
Prosocial Behaviour	6	6	3*	8
Impact				
Difficulties upset child	1	0	2*	0
Interferes with Peer Relationships	1	1	1	0
Interferes with Learning	1	0	1	0

* indicates score in “abnormal” range (“Scoring the informant-rated SDQ”, 2012).

Overall, as a result of the intervention Peter’s positive play behaviour increased and negative behaviour decreased dramatically, with PND scores of 100% and an effect size estimation of 0.9. Peter’s behavioural difficulties, as rated by the SDQ, also reduced, and this also reduced the interference with learning.

For Tui, the repeated measures showed that positive play behaviour increased while negative behaviour decreased substantially as a result of the CCPT intervention. These positive changes in behaviour correspond well with his eight-measure improvement in his SDQ scores, PND scores of 100% and an effect size estimation of 3.1. Thus, the intervention appeared to result in the reduction in the problem behaviour and the

increase of positive play behaviour of the two children, in particular that the difficulties no longer interfered with their learning.

Chapter 6 Discussion

Discussion of Quantitative Data

Changes in Peter's behaviour are consistent with the observational data. Peter seemed to respond to the intervention quickly. In baseline, he had high levels of problem behaviour and low levels of positive play behaviour. After implementation of the CCPT Peter's positive play behaviour began to increase and continued to show a sharp and steady increase as the intervention progressed. This was supported by SDQ total scores which improved from *abnormal* to *normal*.

The percentage of problem intervals decreased immediately after introduction of the CCPT intervention and was maintained in implementation and follow-up. The teacher-reported SDQ scores for child Tui showed large improvements with the *Total Difficulties* gained score reducing from the *abnormal* at baseline into the *normal* range at follow-up. Tui's scores in other important subscales improved, changing from *abnormal* at baseline to *normal* at the follow-up.

The changes observed in the target children are similar to results reported in other studies. Diken and Rutherford (2005) evaluated the effectiveness of the First Step to Success programme (Walker et al., 1998) in a single-subject design study. This study used *Modified Parten's Social Play Scale* which is similar to the POS measure used in the current study. The PND scores calculated for nonsocial play behaviour were 36%, 64%, 100% and 100%. In another study (LeBel et al., 2012), preschool teachers were trained in delivering a daily report card intervention to reduce disruptive behaviour in students. It used direct observation of disruptive behaviour using partial interval recording in a single-subject design. The PND scores were calculated for all four child-

participants and were 50%, 82%, 92% and 100%, indicating the improvement in reduction of the percentage of intervals with disruptive behaviour. In the current study, PND scores for all children were 100%, showing a decrease in percentage of intervals with problem behaviour. Based on PND data, CCPT appears to have had larger PND scores than in the studies by Diken and Rutherford (2005) and LeBel et al. (2012). This indicates that the CCPT strategies used in the current study may produce similar or larger effects compared to the First Step to Success (Walker et al., 1998) and a daily report card intervention.

The comparison of the teacher-report behaviour rating scale data with other studies shows that the results of the current study are similar to the results reported in other studies. In the Hutchings et al. (2004) study, two out of seven children reduced their SDQ scores from *clinical* to *normal* level, as compared to the present study, in which both children reduced to the *normal* range. This shows that the strategies used in the present study may produce similar effects as the IY Dinosaur programme, and thus supports the need for further research.

The comparison of the current study with quantitative studies was conducted in three ways: (a) by comparing the changes in *clinical* levels reported in those studies with the changes in two children in the current study; (b) by comparing the changes in the mean SDQ scores (if available) to the changes in the children in the current study; and (c) by calculating individual effect sizes for changes in SDQ scores and comparing these with effect sizes obtained for this study calculated using the Added Value Score formula (Ford et al., 2009).

Four quantitative studies were selected for comparison. From these studies, three tested different behavioural training programmes for early childhood teachers and one tested play therapy intervention. The first study (Han et al., 2005) evaluated the effectiveness of the pre-kindergarten RECAP programme (Han, 2001; Weiss et al., 2003) designed for addressing preschool emotional and behavioural problems. It used the CBCL and C-TRF. The effect sizes of C-TRF scores for the treatment group were 0.15 for the *Total Problems*, 0.21 for *Externalising Problems* and 0.13, for *Aggressive Behaviour*.

The second study (Hutchings et al., 2007b) evaluated the effectiveness of the Incredible Years Classroom Dinosaur School Programme (Webster-Stratton & Reid, 2003). It used SDQ (Goodman, 1997) completed by teachers and the SCRS (Kendall & Wilcox, 1979) to measure changes in child behaviour. The mean SDQ scores at pre-intervention were 20 and SCRS were 163 and were in the *clinical* range. Following intervention, the SDQ scores improved from *clinical* to *borderline* range and SCRS scores improved to below the *clinical* level. The total SDQ scores decreased by 7 points. The effect sizes for SDQ scores were 1.8 and 1.5 which is similar to the results of the current study for which effect sizes were large (0.9) for Peter and very large (3.1) for Tui. In the current study, the *Total Difficulties* gained score for Peter reduced from the *abnormal* (16) at baseline into the *normal* (11) range at follow-up and decreased by 5 points. Similarly, for Tui, SDQ scores reduced from the *abnormal* (25) at baseline into the *normal* (4) range at follow-up, and decreased by 21 points.

The third comparison study (Larmar et al., 2006) tested the effectiveness of the Early Impact (EI) Programme (Larmar, 2002) for prevention of at risk for conduct problems in preschoolers. Among its measures, the study used the teacher version of SDQ

(Goodman, 1997). The mean SDQ scores at pre-intervention were within the *clinical* range for *Conduct Problems* (7.33) and for *Hyperactivity* (10.03). At follow-up, *Conduct Problems* reduced by one point and *Hyperactivity* scores reduced by two points, which left the scores in the *clinical* threshold. In the current study, scores for *Conduct Problems* reduced by one point only for Peter, whilst Tui's scores in this subscale reduced by 7 points and improved to below the level of *clinical* concern. For hyperactivity subscales, Peter and Tui had noticeable improvements as their scores at follow-up improved to the *normal* range. For Peter the *Hyperactivity* scores reduced by three points while for Tui there was six-point reduction.

In the fourth quantitative study selected for comparison (Bratton et al., 2013), preschool children identified with *clinical* levels of disruptive behaviour received CCPT in their preschools. Changes in child behaviour were measured using the C-TRF. At baseline, the mean scores for *Externalising Problems* were 63.00 and 63.55 for *Aggressive Behaviour* indicating a *borderline* range. After the intervention, scores for *Externalising Problems* improved to the *normal* range, reducing by an average of five points.

Similarly, *Aggressive Behaviour* scores returned to the *normal* range with an average of five-point reduction. The calculated effect sizes pre-and post intervention were 0.7 for *Externalising Problems* and 0.7 for *Aggressive Behaviour*. These results are similar to the results of the current study in which children's total SDQ scores improved to the *normal* range and the effect sizes for both children were large.

Overall, based on the comparison of observational data, changes in *clinical* levels of problems, SDQ scores, and effect sizes, CCPT appears to have resulted in as many or greater improvements as in other studies.

Discussion of Qualitative Data

Looking through teachers' data, strong themes emerged. I will use those themes to discuss a comparison of the qualitative findings with findings in other studies

Consistent with findings in other studies, teachers in this present study found CCPT training beneficial in bringing about improvements in the behaviour of the target children Peter and Tui. Helker and Ray (2009), for example, found that teachers who participated in play therapy training reported a variety of positive changes in their students' behaviour, including students' improved capacity to deal with anger, increased self-control and self-responsibility and improved confidence. One teacher in their study reported that her student had developed the capacity to manage frustration and regulate emotions (Helker & Ray, 2009). In the present study, Cathie reported an increase in empathy in Peter and his improved self control over aggression. Lee commented on Tui's strengthened ability to express his feelings to others rather than act in destructive ways.

Teachers in this study also reported positive changes in the behaviour of other children in their centre. In addition, teachers seemed to transfer their knowledge of play therapy strategies easily in their interactions with other children in their classroom. This appeared to have led to a reduction in behaviour problems. This is consistent with the findings of Edwards et al. (2009) who reported that teachers were able to incorporate their knowledge of play therapy strategies into their interactions with other children. In the present study this seems to have led to a reduction in behaviour problems in children, and helped teachers develop a more positive classroom climate.

In the current study teachers appeared to have also gained an improved ability to accept and understand children. For example, Lee reported that her relationship with Tui became warmer and more meaningful as a result of the CCPT training. In addition, Cathie stated that the CCPT training helped her build a more trusting relationship with Peter. This is consistent with the findings of Helker and Ray (2009) and Sepulveda et al. (2011) who found that teacher training in play therapy resulted in teachers' improved capacity to understand children, and their increased empathy toward the children. In the study by Sepulveda et al. (2011), for example, several teachers commented that they became more understanding of and connected with children and that "actual bonding took place" (p. 20) as a result of play therapy intervention.

Another benefit from the CCPT training was that the teachers felt that they had regained a feeling of confidence and self-efficacy in their teaching role. Lee reported that CCPT had helped her to realise that she can make a big difference in children's behaviour by providing children with regular, focused attention. In addition, Cathie indicated that the training had increased her ability to engage with children to help them develop their social and academic skills. This is consistent with the findings of Sepulveda et al. (2011), as one of the powerful themes emerging in their study was teachers' increased confidence in managing a preschool classroom. For example, one of the teachers in their study expressed confidence in managing children's behaviour effectively with her newly learned skills (Sepulveda et al., 2011). Helker and Ray (2009) also reported that as a result of training in play therapy strategies, teachers appeared to have seen themselves as an important vehicle for change.

Teachers in the present study also seemed to uncover more in-depth benefits of CCPT to children. Cathie, for example, in her reflections and verbal comments frequently pointed to the usefulness of play therapy strategies to children's language development, their communication, social skills and emotional literacy. Lee also acknowledged the value of play therapy in the development of children's vocabulary, emotional literacy, and ability to self-regulate. This is consistent with the findings of other studies (Edwards et al. (2009); Helker & Ray (2009); Sepulveda et al. (2011)) showing that teachers had found play therapy strategies an important tool by which they could promote children's language, social and academic development. Helker and Ray (2009) also cite teachers' comments regarding the perceived value of CCPT in the development of children's confidence and self-regulation.

A further benefit of the CCPT training emerging from the data was related to unanticipated personal/professional development in teachers. For Cathie, this involved taking a risk when implementing the strategy of describing children's actions instead of question-asking. At the beginning Cathie seemed quite sceptical about this strategy. This situation is not uncommon. Edwards et al. (2009), for example, reported instances when teachers experienced difficulty with the idea of describing children's actions and tended to ask a lot of questions. Landreth et al. (2009) also found that this strategy is often viewed by teachers as unproductive and not beneficial for a child's learning and development. For these reasons, some teachers may resist the idea of following the child's lead in play, especially with those children who do not perform well academically or have behaviour problems (Landreth et al., 2009).

Lee seemed to transfer her CCPT knowledge into another area of her life. For example, she was able to help her sister struggling with putting her young child to bed by using newly learned strategies. Lee skilfully described her nephew's actions and emotions and succeeded in putting him to bed. Similarly, results of a study by Hess et al. (2005) showed that positive impacts of play therapy training transferred beyond teachers' professional domain. For example, one teacher stated that it was her view of herself that changed as the result of the training (Hess et al. 2005). In addition, in a study by Helker and Ray (2009) teachers reported a change in their way of being with children, specifically being more patient with children and trying to see things from the children's perspective (Helker & Ray, 2009). In the present study, it seems that both teachers were able to experience some unexpected yet beneficial changes as a result of play therapy training.

Overall, consistent with findings from comparison studies reporting teachers' perceived benefits of CCPT training, teachers in the present study reported that CCPT training had brought positive changes in children's behaviour, an increased ability to accept and understand children, improved level of confidence and self-efficacy in their teaching role, and gains to personal and professional development.

Social Validity

The social validity of the study was demonstrated in three aspects (Turan & Medan, 2011). The reduction in the problem behaviour of the two children, and the improvement in the skills of the two teachers in addressing problem behaviour are very important because of the overall impact of problem behaviour on society (Blissett et al., 2009a; Carr, 2009a; Scott, 2008; Webster-Stratton, 2012). The teachers found the

intervention acceptable and intended to continue using the skills they learned, and they were very satisfied with the intervention outcomes. Although children did not report directly on their own satisfaction, the changes in their play, and their apparent happiness, are further evidence as to the social validity of the study outcomes.

Limitations of the Present Study

There are a number of methodological limitations to the present study, including phase length and measures. One of the principal limitations was the phase length, in particular, the number of observations during baseline. It is suggested that baseline consist of five observations (Alberto & Troutman, 2009). The present study has four observations, but these are spread over 2 weeks. In addition to the observations, teacher reports of behaviour were collected. Thus, although the study may be slightly weakened by four observations, the period of time covered by the observations and the teacher report component provide some confidence that the baseline measures were representative.

A related limitation is the observed variability in problem behaviour during baseline. It is suggested that baseline continue until performance is stable, to assist in the visual interpretation of the data (Alberto & Troutman, 2009; Kazdin, 1982). In the present study, the problem behaviours and positive play behaviour of Tui and Peter were variable. However, it was not possible to extend baseline because the teaching training had been scheduled to occur on a particular day. It was necessary to have the training on this day, planned in advance, in order to have relieving (substitute) teachers, and because the teachers needed to plan the dates in advance. In addition, behavioural variability can be seen in the baseline performance in other studies (Diken &

Rutherford, 2005; LeBel et al., 2012). Thus, although the study could have been strengthened by an extended period of baseline observations, the methodology of analysis has addressed this limitation.

Another limitation of the study is utilising teachers who were involved in the CCPT training as the source of data on target children. This increases the possibility that rather than representing the child's true behaviour change, teachers' changed perceptions of target children, as a result of CCPT, may have influenced their SDQ and qualitative data reports. However, the researcher's observational data is consistent with teachers' reports and shows significant improvements in children's behaviour. Furthermore, as cited in the literature review, studies have shown the link between positive teacher perception, child-teacher relationship and behaviour of students (Hamre & Pianta, 2005; Thomas et al., 2011). Thus, although there was a potential for teachers not to be completely objective, this was not supported by the literature and the results of the current study.

Further limitations of the current study include the absence of the parent report measures, measures of other areas where a child might have improved, and the lack of reliability of the data. Without parent reports it is difficult to know if improved behaviour generalised to the home environment. Measures of other areas of improvement such as speech and language, problem-solving and empathy could have helped to determine whether CCPT could be potentially helpful for children with conduct problems also presenting with problems in other areas of development. In addition, the current study has no reliability data collected on observation data. In the

present study, it was not possible to identify and train a second observer due to limited time.

Finally, also due to time constraints, the researcher was not able to share the identified qualitative themes with the participating teachers for their review. Their additions and possible corrections could have enhanced the study credibility. At the same time, this limitation may not be major as there is now evidence from a number of studies that reviewing qualitative research findings with participants raises a number of methodological, moral and ethical concerns (Goldblatt, Karnieli-Miller, & Neumann 2011; Hagens, Dobrow, & Chafe, 2009; Mero-Jaffe, 2011). These authors argue that encouraging participants to review transcripts and the researcher's data interpretation may invite new perspectives which may be quite different from those originally caught in the interview. For this reason, they argue that it is not necessarily the best method for achieving credibility.

Implications of the Results for Early Childhood Education Centres

Findings from this study show that teachers can help children with conduct problems to develop positive social behaviour and reduce problem behaviour. According to Morrison and Bratton (2010) and Webster-Stratton et al. (2011), teachers are instrumental in helping their students with conduct problems to develop emotional literacy, social skills and ability to self-regulate which are essential for academic success. However, there has been some debate that in a busy preschool environment, teachers may have limited time to engage in quality interactions with children having conduct problems. This study shows that even as little as 15 minutes of focused teachers' time twice a week may be enough to reduce problem behaviours and promote

positive play behaviour in such children. Therefore, the CCPT has the potential to become a viable option for even the busiest early childhood education settings.

Findings from this study also highlight the importance of offering early childhood teachers interventions that are suitable for the New Zealand early childhood education context and can be easily linked to *Te Whāriki* (Ministry of Education, 1996). Blissett et al. (2009) suggest that one of the challenges with translating interventions for conduct problems into a New Zealand context was “identifying the mix of programmes that is most likely to be suitable for New Zealand given current social conditions, funding and skill resources” (p. 28). This study shows that the effectiveness of CCPT may be partly related to the teachers’ acceptance of the training, due to its links with *Te Whāriki* (Ministry of Education, 1996). If the CCPT intervention were effective in other early childhood education settings, as it appears to have been in this study, it may potentially become an effective intervention which may fit the unique early childhood education context of New Zealand. Due to the limitations, however, it is important that the present findings are interpreted with caution.

Implications for Further Research

There is a need to better understand to what extent interventions ensure cultural sensitivity and fit with diverse populations (Blissett et al., 2009; Fergusson et al., 2009). It is suggested that interventions with culturally diverse populations may not be effective due to a failure to consider differences in values, child-rearing practices, language and contextual stressors distinctive to particular cultural groups (Webster-Stratton, 2009). For instance, Asian families in New Zealand may experience a number of stressors specific to their population, such as language and post-migration stresses, as

well as a lack of support from other relatives, and parental separations (Blissett et al., 2009). Thus, further research evaluating the delivery of the CCPT intervention to a group of children who come from diverse cultural backgrounds would possibly provide an insight into whether CCPT has the potential to be a culturally sensitive intervention and whether its principles are easily generalisable across cultures.

There has been considerable research on children participating in play therapy, but teachers' experiences of CCPT remain less well understood. Given that in New Zealand teachers report increasing difficulties in dealing with growing levels of conduct problems in young children (Ministry of Education, 2012), further research which gathers and evaluates perspectives of teachers concurrent with data on child behaviour change is needed. Apart from providing a more solid empirical base, this research may lead to the creation of more effective and appropriate CCPT interventions which may prevent the development of adverse long-term outcomes associated with these problems.

To further assess the efficacy and acceptability of the CCPT intervention, replication of the current study in diverse early childhood settings with children without conduct problems may be needed. This research may provide a useful examination of the effectiveness and cultural acceptability of CCPT in New Zealand. Further studies in this area may also consider delivering CCPT training to culturally diverse populations of teachers. Training multicultural groups of teachers can promote greater understanding about cultural sensitivity of the CCPT and its potential fit with culturally diverse populations. Moreover, training culturally diverse teachers can possibly promote greater

acceptance of the programme among parents from diverse cultural backgrounds, which may enhance the effectiveness of the intervention with multicultural groups of children.

Conclusion

This study shows that child centred play therapy strategies may be a worthy option in providing early childhood teachers with more skills to address conduct problems in children. The study findings indicate that teachers can quickly learn and implement CCPT skills within their centre to positively affect children's behaviour. Some useful information emerged on teachers' perceptions of the CCPT training. It is hoped that this study will generate more interest in CCPT among early childhood teachers and will increase efforts to add CCPT to a portfolio of evidence-based interventions for addressing childhood conduct problems.

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Appendices

Appendix A: Human Ethics Committee Approval Letter



HUMAN ETHICS COMMITTEE

Secretary, Lynda Griffiths
Email: human-ethics@canterbury.ac.nz

Ref: 2012/28/ERHEC

16 July 2012

Aleksandra Gosteva
Health Sciences Centre
UNIVERSITY OF CANTERBURY

Dear Aleksandra

Thank you for providing the revised documents in support of your application to the Educational Research Human Ethics Committee. I am very pleased to inform you that your research proposal "The effects of teacher delivered child centred play therapy-based strategies on children's social play behaviour" has been granted ethical approval.

Please note that should circumstances relevant to this current application change you are required to reapply for ethical approval.

If you have any questions regarding this approval, please let me know.

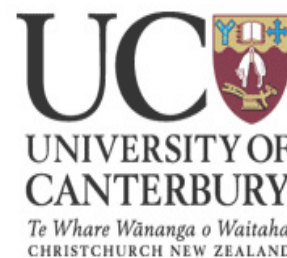
We wish you well for your research.

Yours sincerely

A handwritten signature in black ink, appearing to read 'N Surtees'.

Nicola Surtees
Chair
Educational Research Human Ethics Committee

Appendix B: Discussion and Information Sheets for Centre Manager and Teachers, Consent Form for Centre and Teachers



Health Sciences Centre

Tel: +64 3 364 2987 ext. 3108, Fax: +64 3 364 3318,

Discussion and Information Sheet for Centre Manager

To be discussed in a face-to-face meeting with the Centre Manager

Discussion and Information Sheet for Teachers

To be discussed in a face-to-face meeting with the Centre Manager and Teachers

My name is Alex Gosteva. I am a student at the University of Canterbury currently studying towards a Masters of Health Sciences endorsed in Early Intervention. As part of my degree, I am required to complete a masters thesis and I would like you and children you nominate to be involved in the research. The provisional title of my thesis is:

The effects of teacher delivered Child Centred Play Therapy-based strategies on children's social play behaviour

I am inviting your Centre to participate in this project. Participation is voluntary. If you change your mind at any time, you have the right to withdraw from the project and withdraw any information you have contributed, without penalty of any kind.

The main steps involved would be:

1. Arranging a meeting with the teachers and yourself to discuss the study with me, the researcher. At the meeting, I will review the information about the study and answer the teachers' questions about the study. There is a written consent form for the Centre Manager and the Teachers about participating in the study.
2. If you and the teachers consent, 2 teachers would be released to participate in a total of 6 hours and 40 minutes of training, provisionally scheduled across three days. The specific dates of the training would be negotiated with you and the teachers and the researcher. The cost of relievers for the training time will be paid by the researcher to the Centre. In addition, the travel costs for the teachers to attend the training at the University of Canterbury will be reimbursed to the teachers. The training will be delivered by the researcher, who is a trained Child Centred Play Therapy practitioner, an early childhood teacher registered in New Zealand and a trained early interventionist. The trainer will follow a manual of play therapy strategies (Ray, 2011) tailored specifically for early childhood teachers for this research project. Teachers will receive a certificate for participation in the training at the end of the study.

3. Before the training, the teachers would nominate children with whom they might trial the strategies. The nominated children will be the ones that the teachers feel are most likely to benefit from the strategies after finding out about what these entail. Nomination would involve providing information on the child's strengths and difficulties, using the Strengths and Difficulties questionnaire. This information would not be provided to the researcher unless the parent consented to the child's participation.

4. Information about the study would be provided to parents (by me), and I would be available at drop-off and pick-up times at the Centre to discuss the study with parents and answer their questions. Only children whose parents give written consent will participate in the study. After the trial of the strategies, teachers would again provide information on the strengths and difficulties of children for whom consent was received.

5. If you and the teachers consent, each teacher would trial the strategies in 15 minute sessions following training for ten weeks, twice per week with one child for whom parent consent was received. Strategies may take time to produce an effect, so it is necessary to trial them for that period. The researcher would be available to provide feedback, and support to the teachers on request by the teachers. The researcher will not be observing the teachers. The teachers will also provide information on the children's strengths and difficulties after the conclusion of the trial period (about 10 minutes per child) and complete a questionnaire about how satisfactory they found the training and the strategies (about 10 minutes).

6. The researcher would observe the nominated children (for whom parental consent is received) for about 10 minutes twice a week during free play activities. The specific schedule would be worked out with the teachers to cover two weeks before the training of the teachers, ten weeks while they trial the strategies, and two weeks afterwards. These observations will not be taken while the teacher is trialling the strategies with the child. These observations record the child's social behaviour during free play.

I believe that the strategies from Child Centred Play Therapy will be beneficial to the Centre. Teachers will benefit because they acquire new strategies of strengthening positive play relationships with the nominated child (Ray, 2007; Ray, Henson, Schottelkorb, Garofano Brown, & Muro, 2008). Research has shown that these strategies have potential benefits for children by helping children grow emotionally and learn self-regulation and self-control (Landreth, 2002).

I believe that early childhood teachers can learn to use these strategies effectively as an alternative to other forms of behavioural management. The concept of child centred play forms a basis for Te Whariki - the New Zealand early childhood curriculum (Ministry of Education, 1996) which makes strategies of Child Centred Play Therapy particularly relevant to the New Zealand early childhood context.

There are no known risks of participating in this research study.

The results of this study will be used to help understand how teachers may use play-therapy based strategies to scaffold children's social play in early childhood centres. To ensure your privacy, I will not be discussing or writing about the

identity of your centre, the teachers, or the children/parents. All information will be kept strictly confidential, and anything that might allow identification will not be revealed in my thesis or any reports based on the study. The study will have a comprehensive security system, with all information you provide being stored anonymously on computer files. All raw data will be held securely and kept for a minimum period of 5 years following completion of the project and then destroyed.

The results of the study will be available from the UC library website and may be published in a national or international journal or presented at a conference. You will receive a summary of the study and may ask at any time for additional information or results of the study, after it is completed.

This research has received ethical approval from the University of Canterbury Educational Research Human Ethics Committee. You should address any complaints to The Chair, Educational Research Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

The next step in planning for this study would be to schedule a meeting with the teachers. At this meeting, these details about the study will be discussed. If you are interested having me talk to the teachers, please email me or give me a call, or I will check back with you in a week.

In the meantime, if you have, any questions please feel free to contact either Dr. Liberty (kathleen.liberty@canterbury.ac.nz) or me, Alex Gosteva (telephone: 021 187 2112; email: ago24@uclive.ac.nz).

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Consent Form for Centre and Teachers

The effects of teacher delivered Child Centred Play Therapy-based strategies on children's social play behaviour

I have been given a full explanation of this project and have been given an opportunity to ask questions.

I understand what will be required of me if I agree to take part in this project.

I understand that my participation is voluntary and that I may withdraw at any stage without penalty of any kind, including withdrawal of any information I have provided.

I understand that any information or opinions I provide will be kept confidential to the researcher and that any published or reported results will not identify me.

I understand that all data will be held securely and kept for a minimum period of five years following completion of the project and then destroyed.

I understand that I will receive a report on the findings of this study which will be sent to the Centre.

I understand that if I require further information I can contact the researcher, Alex Gosteva. If I have any complaints, I can contact the Chair of the University of Canterbury Educational Research Human Ethics Committee.

By signing below, I/we agree to participate in this research project.

Teacher Name: _____

Signature: _____ Date: _____

Teacher Name: _____

Signature: _____ Date: _____

Teacher Name: _____

Signature: _____ Date: _____

Name of Centre: _____

Director Name: _____

Signature: _____ Date: _____

Please return this completed consent form to Alex in the envelope provided by 03/10/2012-one week after the meeting or phone Alex on 021 187 2112 and she will pick-up. If you do not want to consent, do not sign the form.

Appendix C: Information Sheet and Consent Form for Parents and Children

Health Sciences Centre

Associate Professor Ray Kirk
Director, Health Sciences Centre
Tel: +64 3 364 2987 ext. 3108, Fax: +64 3 364 3318,
Email: ray.kirk@canterbury.ac.nz



Information Sheet and Consent Form for Parents and Children



Dear Parent and Son/Daughter. This information has been sent to you by your child's early childhood teacher, who believes that you and your son/daughter may be interested in participating. This is a University of Canterbury masters student research project.

My name is Alex Gosteva. I am a student at the University of Canterbury currently studying towards a Masters of Health Sciences endorsed in Early Intervention. As part of my degree, I am required to complete a thesis and I would like to invite your child to participate in this research. The provisional title of my thesis is:

The effects of teacher delivered Child Centred Play Therapy-based strategies on children's social play behaviour

The aim of this project is to investigate effects of teacher using strategies based on Child Centred Play Therapy on children's social play behaviour.

The Centre and teachers are interested in this study and have nominated your child to participate in a trial of special strategies to enhance children's social play.

Participation in this study means that your child's teacher will complete the Strengths and Difficulties Questionnaire (Goodman, 1997) that is part of the B4 School Check (a copy of which is displayed on the centre's notice board) or I am happy to send you a copy.

Your child may also receive some new play interactions from the teacher following teacher training, as the teachers trial them over a ten week period. The teachers will learn the strategies over three days and decide what children with whom they wish to trial the strategies. The strategies will be used in the centre during free play activities for 15 minutes twice per week for about ten weeks or one school term. We can't know ahead of time which children will receive the strategies.

Your child's social play behaviour may also be observed by the researcher before the teachers are trained and after they are trained. The study will also involve the researcher obtaining information on your child's age, and ethnicity, from their teachers.

I believe that the strategies from Child Centred Play Therapy may be beneficial to children. Research has shown that these strategies have potential benefits for children by helping them develop their social, emotional, and problem solving skills for play interactions with each other (Landreth, 2002). This may or may not happen for your child.

Participation in this study is voluntary. If you change your mind at any time, you have the right to withdraw your child from the study without penalty. You can also withdraw any information about your child without any penalty.

There are no known risks for participating in this study.

I will not be discussing or writing about any child's identity, or any identifying information. All information will be kept strictly confidential, and anything that might allow identification will not be revealed in my thesis or any reports based on the study. The study will have a comprehensive security system, with all information being stored anonymously on computer files. All raw data will be held securely and kept for a minimum period of 5 years following completion of the project and then destroyed.

The results of this study will be used to help understand how teachers may use play-therapy based strategies to scaffold children's social play in early childhood centres. The results of this research may be reported in professional journals. A summary of the findings of the study will be available through the centre, about 6 months after the study is completed.

The project has been reviewed and approved by the University of Canterbury Educational Research Human Ethics Committee. You may address any complaints to The Chair, Educational Research Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

I will be at the Centre on the mornings of 01.10 and 02.10 from 8.00am-9.30am and afternoons of 04.10 and 05.10 from 4.30pm-5.30pm if you wish to meet me. I am also happy to meet you to discuss the research or of course you can contact me on telephone: 021 187 2112; email: ago24@uclive.ac.nz) or you can contact my supervisor Dr Liberty on 027 3490645 (kathleen.liberty@canterbury.ac.nz).

In addition, after you have had your questions answered, we wish you to discuss this with your child. On the next page is a suggested way to talk about the project for a child who is about three years old. I am also happy to talk to your child about this if you contact me as above.

Please go on to the next page.

Please read and talk to your child about the study:

A lady named Alex is doing a project at the university. She is going to work with your teachers and teach them new ways to play with children. She is asking if you will help the teachers learn these skills. She will watch you play and take notes about what you do and how you do it. She will also ask the teachers at your Kindy about your playing. As you have been selected, you will be given a code name so that no-one will know your name, the name of the teachers or the centre. Your teacher is also part of this study. If you have any questions, you can talk to your Mum or Dad or to your teacher or to Alex. If you change your mind about being in the project, that's fine, too. All you have to do is to tell your Mum or Dad or your teacher or Alex.

Thank you for helping with the project.

If you give permission for your child to participate, please complete the attached form and post it to me in the enclosed envelope by 05.10.2012. If you do not give permission, do not sign the form.

Thank you for your consideration.

Alex Gosteva

01.09.2012

References

- Goodman, R. (1997). The Strengths and Difficulties Questionnaire: A research note. *Journal of Child Psychology and Psychiatry*, 38, 581–586.
- Landreth, G. L. (2002). *Play therapy: The art of the relationship* (2nd ed.). New York: Brunner-Routledge.

Health Sciences Centre

Associate Professor Ray Kirk
Director, Health Sciences Centre
Tel: +64 3 364 2987 ext. 3108, Fax: +64 3 364 3318,
Email: ray.kirk@canterbury.ac.nz



Consent Form for Parents and Their Son/Daughter

The effects of teacher delivered Child Centred Play Therapy-based strategies on children's social play behaviour

I have been given a full explanation of this project and have been given an opportunity to ask questions.

I understand what will be required of me and my child if I agree to take part in this project.

I understand that my child's participation is voluntary and that I may withdraw at any stage without penalty.

I understand that any information or opinions I provide will be kept confidential to the researcher and that any published or reported results will not identify me or my child.

I understand that all data collected for this study will be kept in locked and secure facilities at the University of Canterbury and will be destroyed after five years.

I understand that I will receive a report on the findings of this study. I have provided my postal details below for this.

I understand that if I require further information I can contact the researcher, Alex Gosteva. If I have any complaints, I can contact the Chair of the University of Canterbury Educational Research Human Ethics Committee.

By signing below, I agree to the participation of my child in this research project.

I have discussed this project with my child, and she/he has made a mark below.

Name of Child _____ Child's Mark _____

My Name: _____

My Signature: _____ Date: _____

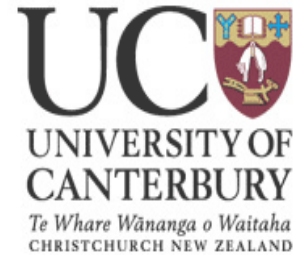
Address to which the report is to be sent: _____

Please return this completed consent form to Alex in the post-paid envelope provided by 05.10.2012. Do not complete if you do not give permission.

Appendix D: Teacher Background Questionnaire

Health Sciences Centre

Associate Professor Ray Kirk
Director, Health Sciences Centre
Tel: +64 3 364 2987 ext. 3108, Fax: +64 3 364 3318,
Email: ray.kirk@canterbury.ac.nz



Teacher Background Questionnaire

To be completed with a teacher in a face-to-face meeting

Teacher's Name: _____ Teacher's Gender: _____

Date of Birth: _____

Teacher's Ethnicity (Please tick):

NZ European	<input type="checkbox"/>	Cook Islands Maori	<input type="checkbox"/>	Chinese	<input type="checkbox"/>
Maori	<input type="checkbox"/>	Tongan	<input type="checkbox"/>	Indian	<input type="checkbox"/>
Samoan	<input type="checkbox"/>	Niuean	<input type="checkbox"/>	Other such as Dutch, Japanese, Tokelauan. Please state:	<input type="checkbox"/>

Language(s) spoken at home: _____

Months/Years employed at this centre: _____

Highest early childhood qualification: _____

Examples: Diploma of Teaching, Bachelor of Teaching and Learning (Early Childhood), Master of Education, etc.

Years of teaching experience: _____

Why do you think it is important to address behaviour problems in children:

(continue on back)

Appendix E: Child Background Questionnaire

Health Sciences Centre

Associate Professor Ray Kirk
Director, Health Sciences Centre
Tel: +64 3 364 2987 ext. 3108, Fax: +64 3 364 3318,
Email: ray.kirk@canterbury.ac.nz



Child Background Questionnaire

To be completed with a teacher in a face-to-face meeting

Child's Name: _____ Child's Gender: _____

Date of Birth: _____ Age: _____

Child's Ethnicity (Please tick):

NZ European	<input type="checkbox"/>	Cook Islands Maori	<input type="checkbox"/>	Chinese	<input type="checkbox"/>
Maori	<input type="checkbox"/>	Tongan	<input type="checkbox"/>	Indian	<input type="checkbox"/>
Samoan	<input type="checkbox"/>	Niuean	<input type="checkbox"/>	Other such as Dutch, Japanese, Tokelauan. Please state:	<input type="checkbox"/>

Language(s) spoken at home: _____

Months/Years attending this centre: _____

Attendance pattern (Please tick attendance times):

Day	Monday	Tuesday	Wednesday	Thursday	Friday
Session					
Morning					
Afternoon					

Appendix F: Strengths and Difficulties Questionnaire

Strengths and Difficulties Questionnaire

P 4-10

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's behaviour over the last six months.

Your child's name

Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other children, for example toys, treats, pencils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often loses temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rather solitary, prefers to play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally well behaved, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries or often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, depressed or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets along better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good attention span, sees chores or homework through to the end	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

Overall, do you think that your child has difficulties in one or more of the following areas:
emotions, concentration, behaviour or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FRIENDSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLASSROOM LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEISURE ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature

Date

Mother/Father/Other (please specify:)

Thank you very much for your help

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Appendix G: Play Observation Scale

Play Observation Scale Coding Sheet (2001)

Name of Child: _____ ID _____ Cohort _____ Age _____

Free Play Session _____

	Time Sample					
	:10	:20	:30	:40	:50	:60
uncodable						
out of room						
transitional						
unoccupied						
onlooker						
Solitary Behaviors:						
Occupied						
Constructive						
Exploratory						
Functional						
Dramatic						
Games						
Parallel Behaviors:						
Occupied						
Constructive						
Exploratory						
Functional						
Dramatic						
Games						
Group Behaviors:						
Occupied						
Constructive						
Exploratory						
Functional						
Dramatic						
Games						
Peer Conversation						
Double Coded Behaviors:						
Anxious Behaviors						
Hovering						
Aggression						
Rough-and-Tumble						
Conversation/Interacting With:	1	2	3	4	5	6

Appendix H: Teacher Satisfaction Questionnaire

Health Sciences Centre

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Teacher Satisfaction Questionnaire

To be completed with a teacher in a face-to-face meeting at the end of the study

Teacher's Name: _____

Date: _____

1. How helpful was the Child Centred Play Therapy training?

not helpful at all	not helpful	neutral	helpful	very helpful
1	2	3	4	5

Comments:

2. My overall feelings about the Child Centred Play Therapy training are:

very negative	negative	neutral	positive	very positive
1	2	3	4	5

Comments:

3. Would you recommend the Child Centred Play Therapy training to others?

strongly not recommend	not recommend	neutral	recommend	strongly recommend
1	2	3	4	5

Comments:

4. How confident you are in your ability to manage future problem behaviour at your centre using the strategies based on Child Centred Play Therapy?

not confident at all	not confident	neutral	confident	very confident
1	2	3	4	5

Comments:

5. What was most helpful about the training you have received?

Comments:

6. How could the Child Centred Play Therapy training have been improved to help you more?

Comments:

Thank you